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Children at Christmastime

CHRISTMAS is traditionally the children's festival. True, we older folk like to bask in the glow of their happiness. But, in thousands of homes throughout this Canada of ours when Christmas trees are decorated, stockings are hung up and gifts are interchanged, the primary motif is the pure, unadulterated joy that comes to the children. Where we grown-ups carefully untie the beautifully wrapped gifts and treasure the gay wrappings, the children shred the coverings in their eagerness to see what each parcel contains. Then comes the fun of trying out new toys. Precariously, a few cautious strokes are taken on the coveted roller-skates. Every garment in dolly's wardrobe is smoothed and admired. It is Christmas—the time of heartwarming gladness and fun. It is Christmas in Canada.

Elsewhere in the world, a dimmer picture prevails. Millions of children who do not bear a single responsibility for the all-devastating disaster of war, but who are still feeling the full effect of its bitterness and its fatal consequences are sad, hungry, suffering. To ease their intolerable conditions, to provide such basic requirements as food and clothing, the United Nations Appeal for Children was launched in December, 1946. From a small beginning, it has now become a world movement in which the peoples of fifty-two countries and thirty non-self-governing territories have carried on campaigns to raise funds to assist in the noble work of aiding these children. The General Assembly of the United Nations, in creating the United Nations International Children's Emergency Fund, laid down the principle clearly and definitely that "distribution must be on the basis of need, without discrimination because of race, creed, nationality status, or political belief." This principle has been scrupulously observed.

In the European program, as its initial undertaking, UNICEF is helping to provide a daily supplementary meal for over four million children, and nursing and pregnant women in a dozen countries. The Fund is also making arrangements to help meet the great need for children's clothing and shoes through the provision of raw wool, cotton, and leather from which the receiving country will process the finished articles. A similar program

is underway in China and in other countries of the Far East. Millions of children to be helped!

In an effort to check the spread of tuberculosis among children, UNICEF is assisting in mass vaccination programs in a number of European countries. These programs have been developed as a joint enterprise with the Danish Red Cross and its associates in Norway and Sweden. The World Health Organization is co-operating in this project. It promises to be the largest single mass immunization ever undertaken.

Fifty million European children are to be tested, and those found free of infection will be inoculated with BCG vaccine. The vaccine comes mainly from Denmark. Examination of the children and their inoculation is done by teams comprising a doctor, nurse, and technician. These teams are made up of Scandinavians who have had the necessary experience. As the work progresses local personnel will carry more and more of the responsibility. Adequate records are being kept and the wealth of factual material now being gathered will be of great value to medical science.

* * *

Millions of dollars have been donated. Still more millions are needed. When you are doing your own Christmas shopping, when you receive your own gifts, give a thought to these world-wide needs and be generous.

Advances in Diabetes Mellitus

D. M. BALTZAN, M.D., F.R.C.P. (C.)

THE PRESENT discussion is confined to remarks on selected practical problems concerning diabetes mellitus.

INCIDENCE

There are several *sources* for the increased number of diabetics: (1) The childen who have been saved since the insulin era are with us. (2) These grown-up diabetics are parents whose children are more often diabetics than others. (3) People who have diabetes live longer. (4) The notable age prolongation of the general population brings more people into the "diabetic zone."

There are other reasons for the *apparent increase* in the number of diabetics: (1) Diabetes is more prevalent among the higher bracket income groups and the standard of living has improved on this continent. (2) The ready recourse of the general public to routine physical examinations makes possible the frequent discovery of glycosuria before symptoms of diabetes develop.

It may, therefore, be said that the greater incidence is a tribute to medical progress; the saving of many lives makes more diabetics among us, and the early detection of the disease does likewise. But greater progress still will be measured by a lowered incidence of diabetes in the face of these advances. That can be expected through the better knowledge of the control of the inciting forces.

CAUSATION

There is no specific cause of diabetes. Diabetes develops in the presence of a distinct hereditary predisposition. The predisposition may be present and without provocation the disease may remain dormant. White and Pincus observed:

When both parents have diabetes *all* their children have diabetes if they live long enough; when one parent has diabetes and the other is a diabetic carrier 40 per cent of their children may be expected to develop diabetes; if a diabetic or carrier marries a non-diabetic or

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non-carrier, none of their children will have diabetes though all will be carriers. Outbreeding of the disease by selected marriage is, therefore, a possibility.

The disease is mostly invoked through mischievous, extra-pancreatic factors at work. If these are continued the disease is brought about through the *ultimate* failure of the islets of Langerhans. Not all the precipitating agents responsible for the onset are known. Some are known and cannot be checked.

The disturbances in glandular balance, chiefly the pituitary, adrenal cortex, and thyroid gland secretion rank first. The disturbances are sometimes physiological and sometimes physio-pathological. Overactivity of the anterior pituitary gland can lead to diabetes. The anterior pituitary gland regularly exhibits temporary hyperactivities as a physiological event during the period of active growth, pregnancy, and at the menopause. It may well explain the occurrence of peaks in the incidence of diabetes at these times. The adrenal gland plays a similar role, and to a lesser extent the thyroid gland.

Obesity in the majority of people is produced by a diet rich in fats and high in caloric value in spite of some arguments to the contrary. The combination of excess fats and abundance of calories tends to reduce the ability to utilize sugar sufficiently. Haist, Campbell and Best have shown that a diet high in fat leads to a reduction of the insulin content of the pancreas; a diet high in carbohydrate leads to an increased content. The popular misconception is that an increased consumption of sugar is commonly associated with diabetes. An excessive carbohydrate consumption in itself is not a direct cause of the disease. It might be interjected here that it is by virtue of these concepts that it is found practicable to treat cases of spontaneous over-productivity of insulin (spontaneous hypoglycemia) by administering a diet high in fat and low in carbohydrates, and not vice versa. The opposite would, on the surface, appear to be the logical course.

Other factors — infections (especially biliary infections) predispose to the development of diabetes in individuals with diabetic potentialities. Arteriosclerosis does not cause diabetes. Tumors of the pancreas occasionally cause diabetes by destruction of the islets of Langerhans.

This part of the material may be summarized by stating that diabetic potentialities exist through inheritance. Contributory conditions precipitate a disturbance in carbohydrate metabolism. The long-continued strain on the insulin-producing pancreas results finally in an insufficiency. If the precipitating factors are recognized, and if they could be removed in time, a normal balance between insulin requirements and the intrinsic insulin supply may again be achieved. This is for the most part a theoretical prospect. These stealthy malefactors creep in unnoticed. The prospect of warding off diabetes can only be achieved by anticipating the development of diabetes. Once diabetes is recognized the factors involved have long been at work. It is not impossible to lessen the disease as, for instance, in the control of obesity, counteracting glandular antagonisms, and by checking any direct (chiefly biliary) infections.

Diagnosis

Proving there is glycosuria and hyperglycemia of a prolonged form is the test in establishing the diagnosis. The presence of glycosuria alone is not a proved sign. Transient glycosuria and transient hyperglycemic peaks must be proved by standard sugar tolerance tests. There are some well-known signs and symptoms which herald the disease, namely, polydipsia, polyphagia, polyuria, progressive loss in weight, etc., but these serve only as clues in forming the diagnosis.

Treatment

Diabetes should be considered as an incurable disease. Therefore, treatment must be regarded as a lifelong obligation. The infliction of the definitive term, incurable, is not as serious as it sounds. In a large number the

treatment is not a hardship. The care necessary to pursue corrected habits may be a nuisance. Strict attention is all that may be required. The results of the effort are profitable. Better health, more vigor, and a longer life can be expected.

Before the commencement of treatment the extent of the diabetes must be recognized and graded. It may, for example, be mild or severe or lethal as when the patient is in a precomatose or comatose state.

Instruction: Specific instruction to the patient is the first obligation because treatment is entrusted to the patient. The mild cases in aged people can be taught out of hospital if there is no demand to follow a strict program. Patients should never be told "to cut down on bread and potatoes and not to eat sweets." On the contrary, they should be directed what to eat and be advised the suitable amounts.

It is an accepted principle in therapy, when the diagnosis is established for the first time, to place the patient in a hospital, for a week or ten days in order to make a good start. Sometimes the wisdom of this advice is questioned. Experience teaches us that every diabetic should receive a proper initiation. The sooner the patient is acquainted with the matters involved, the better is the beginning. The hospital routine, the training, and discipline serve as lasting impressions. The reasons for insisting on the induction in hospital at the start are as follows:

1. To receive proper instruction on the composition of the daily menu as outlined. The diet is prescribed by the physician. It is dispensed by the dietitian. The function of a dietitian is like that of a druggist — to fill the stated portions and dispense them in a balanced menu.

2. To learn the weights and measures of food portions as contained in the diet, and eventually to learn the "feel" of the same.

3. To be taught to examine the urine for sugar and acetone.

4. To receive training in the administration of insulin and the care needed in doing so.

5. To undergo regulation of the diabetes in the shortest time possible. At the end of this short stay in the hospital the diabetes should be under control, and the patient should be fit to resume his regular activities.

6. To be thoroughly indoctrinated in respect to the hazards of infections, injuries, and uncleanliness.

Instruction in the matter of prevention is of a limited nature in the immediate sense. On a broader scope we are sure of the need to side-track the hereditary predispositions. To this end, diabetic patients should not intermarry. A diabetic patient may marry without fear into a family with a clear record. The children of this union should also marry into non-diabetic families.

Avoiding obesity might prevent and frequently will delay the appearance of the disease. In this effort, the emphasis is on a reduction in the amount of fats consumed and that largely accounts for the restriction in the amount of the total caloric intake.

Diabetes is not a contraindication to pregnancy. Pregnancy carries very little risk for the intelligent and cooperative diabetic woman who understands the problems of diabetes. Caesarian section is not a preferential delivery in uncomplicated diabetes.

The diet: A regulated diet of specified carbohydrate, protein, and fat content is paramount because by this means alone mild diabetics are adequately controlled. Diet is equally important when the patient requires insulin. Diabetic patients do not require more or less food than the non-diabetic subject. All diets should be supervised in respect to the vitamin and mineral contents, in addition to all other prerequisites.

There are notorious contrasts in dietary formulae designed for diabetic persons. Their contents are of this order:

1. High carbohydrate — low fat.

2. High fat — low carbohydrate.

3. Relatively high carbohydrate — moderated fat.

4. Free diets with practically no restrictions, advocated for use in children who take insulin.

The relative merits of each is reasonably argued most favorably by the particular advocates.

Our management of the dietary prescription is based on certain conclusions which we reached. In practice, we found that people in this country react best to a relatively high carbohydrate and moderate fat diet. It is recognized as obligatory that the diabetic person should have more than enough carbohydrates to protect ketogenesis, enough proteins to promote growth and replacement, and a matched quantity of fats for fuel and their manifold other functions. Also, convincing research dictates that a surplus of carbohydrates provokes pancreatic insular activity and promotes glycogen storage in the liver. This is a departure from the older view, you must note. Formerly, the diabetic sufferer was spared carbohydrates. We have found extremes in any direction, namely, too high carbohydrates or too high fats make it very difficult to plan a well-balanced attractive menu. It is possible, in treating diabetes successfully, to achieve a menu approximating that which the average person uses. It is, therefore, out of place to concoct a sick man's diet.

It was traditional in outlining a diet to first decide the amount of calories required for the patient. The second step was to calculate balanced portions of carbohydrates, proteins, and fats. As the result of our clinical experiences we merged both steps into one in our plan of therapy.

It is rarely necessary to start with a strictly basal caloric requirement diet. That is only necessary when the patient cannot eat sufficiently, or when he is forbidden to eat for other non-diabetic reasons, or when a strict weight reduction regime is inaugurated at the start. No diabetic person who has an appetite needs to be launched on a starvation menu to begin the regulating ordeal. We start all patients with few exceptions on a uniform prescription.* The diet contains 1800 calories and is composed of 175 grams of carbohydrates, 85 grams of proteins, 85 grams of fat.

The increase or decrease in amounts of 10 per cent of the basic 1800 calorie diet is tabulated in a simple form which the patient can follow. Substitutions and equivalents of portions of common values are listed for easy reference. These provisions are made to create interest and avoid monotony in the daily menu. Extra food allowances for energy expansion does not follow the traditional stipulation of 20, 30, or 40 per cent increases. We proceed by dictates in each individual guided by the need for: (a) satiation of appetite, (b) maintenance of well-being, and (c) control of the patient's weight. The excess weight carriers must be reduced and the malnourished should be fattened, but it is healthier at all times for the diabetic to weigh slightly less than the optimum requirements. Our results in a large series of cases showed the total caloric requirements fell short of the amount customarily advocated as necessary for maintenance at work.

Insulin

Insulin is an antidiabetic hormone produced by the islets of Langerhans. Insulin was first obtained in large quantities by Banting, Best, McLeod, and Collio from beef and pork pancreases. In this original aqueous solution insulin hydrochloride is referred to as unmodified amorphous, plain or regular insulin to which zinc was added at a later date. A later advance was made when insulin crystals were obtained by Abel to which zinc was added, and it was known as crystalline insulin. This preparation is purer and it has a lower protein content. Therefore, there is less likelihood of allergic reactions. The original, unmodified, amorphous inlin, with or without zinc, and crystalline insulin, with or without zinc, are both short-acting insulins. The effect subcutaneously commences within a half hour, and lasts up to six hours.

In 1936, Hagedorn added to insulin a protamine substance obtained

*Baltzan, D.M. A Simplified Plan of Prescribing for Adult Diabetes. *J. Can. Med. Ass'n.* Vol. 57, pp. 54-58.

from the sperm of a species of fish. This resulted in a slower absorption of the insulin after it is injected. The slow absorption produced a retarded insulin effect. By adding zinc the product was made more stable. Protamine zinc insulin has a prolonged and enduring action up to twenty-four and thirty-six hours. All the merits of protamine zinc insulin do not yet make it the ideal preparation.

Newer products have been developed, notably globin insulin. It has a prompt and not as prolonged action as protamine zinc insulin. The duration of its action is about twelve hours. It has no other advantages except that its action is intermediate between rapid and longer acting insulins.

The choice of the type of insulin suitable for each case is a matter of judgment, dictated by the needs of the patient. The factors involved cannot be dealt with now. For those of you who have to administer insulin, and for any that may have to take it, some more relevant remarks may be in order. Rapid-acting insulin may be ordered to be given at the same time as protamine zinc insulin is given. Attention must be paid to the directions. It may be ordered that two insulins, the rapid with the slower-acting form, be given at the same time, but in separate syringes. The rapid-acting insulin takes its fast course at the same time as the other follows its slow course. It may be ordered that both insulins be combined in one syringe. In that case, two things require attention. First, withdraw the plain insulin into the syringe to be used and then draw the extra specified amount from the slower-acting insulin mixture. Secondly, closer attention should be paid to the late results because the combination tends to prolong the effect beyond the expected period of dissipation of the slow-acting insulin used alone. It is well to be reminded it is the unit or *concentration* of the insulin and not the *volume* of the solution that is important.

Whenever possible, one injection a day of any insulin, or any combination of insulins, is the most desirable and best appreciated by the patient. That should be the aim. At times, two injections are compulsory and rarely more, except during complications.

Sparing insulin, and relying on an insufficient diet alone, may bring the blood chemistry within normal limits, but if it reduces body efficiency it is a mistaken kindness. Insulin is indispensable when the sugar tolerance is inadequate to control the blood chemistry, using a suitable diet. The objective in using insulin is, of course, to promote better carbohydrate metabolism. It is planned, at the same time, to keep the blood sugar level within normal limits. With subnormal levels hypoglycemic reactions occur.

At this juncture another interjection is in order. In collecting morning urine specimens for examination, the patient is told to void on arising and this urine is discarded. A second collection is made before breakfast, and it is this specimen which is submitted to analysis.

The diabetic person has a great weakness towards infections. Infections inhibit the action of insulin. The simplest abrasions can lead to the greatest catastrophes. A simple abrasion may incite the events leading to gangrene. An ordinary infection may precipitate coma in an otherwise well-balanced, adequately regulated diabetic person. The diabetic cannot afford the luxuries of neglect, which in other people is taken care of by uninhibited defence mechanisms.

Exercise is beneficial to the diabetic person. Exercise helps reduce body weight or it prevents excess gain in weight. Less insulin is required when the patient is active.

No person should die of diabetic coma. Without exception, coma develops either as the result of some negligence or accident. Death due to diabetic coma is the result either of inadequate treatment or there is a coexisting complication, which is fatal in itself.

Never overestimate the people's knowledge, nor underestimate their intelligence.—
— RAYMOND CLAPPER

Post-sanatorium Rehabilitation

BARCLAY MCKONE, M.D.

INTRODUCTION

FOR MANY YEARS, tuberculosis has been treated in a sanatorium. This was instituted to isolate the patient in order to prevent the spread of disease to others who have not already been exposed to it. It is practically impossible to give the proper form of treatment in the home, even when only bed rest is necessary for this chronic disease. This method of isolation and treatment has certainly proven a powerful weapon in the fight against tuberculosis.

In countries where sanatoria have been established and free treatment put into effect, the annual tuberculosis death rate has been reduced from about 85 or more per hundred thousand population to 25 to 30 deaths per hundred thousand population. The tuberculosis death rate has remained for the past five or ten years somewhat stable and, in order to bring about a further reduction, it is necessary to continue to educate the public to be conscious of the disease, to have a better understanding of it, and the importance of early diagnosis. There is a large scale program in effect at the present time—namely, mass x-ray survey—the purpose of which is to make an early diagnosis and to find the perfectly well, unsuspecting, open cases before they have spread disease to more people.

Another method of fighting tuberculosis takes the form of rehabilitation. Rehabilitation of the tuberculous is not new. It was used in some centres as early as 1914. There are very few people working in the field of tuberculosis who are not aware of the importance of a more complete insanatorium and post-sanatorium form of rehabilitation of the tuberculosis patient. Scattered throughout Canada and other parts of the world there are definite rehabilitation units for patients, and rehabilitation in all the sanatoria is coming more and more into effect. The question arises for a patient receiving rehabilitation: "Of what use is it to me if this rehabilitation cannot be continued during the convalescent period?" The important point here is the fact that about 25 per cent of all admissions to sanatoria in Ontario are re-admissions. Re-admission cases require more treatment than first admissions; re-admission rates are lower where more complete rehabilitation is in effect. It has been said that in the United States about 50 per cent and in Canada 35 per cent of all first admissions return to a sanatorium. Where a well-organized rehabilitation centre is established, and only minimal and moderately advanced cases are treated, the re-admission rate over a five-year period is 6 per cent. It is believed that adequate post-sanatorium rehabilitation will reduce this re-admission rate for all cases (including far advanced pulmonary tuberculosis) to about 12 or 15 per cent. Twelve per cent is the figure quoted by Dr. A. N. Aitken of Niagara County Sanatorium, Lockport, N.Y.

REHABILITATION DEFINED

In order to discuss rehabilitation it is necessary to define what the term really means. Rehabilitation, for our purpose, can be defined as: Treatment of the patient until he may ultimately reach the maximum physical, mental, social, economic, and vocational capacity for future occupation and social security. Most patients may eventually lead normal lives and become normal citizens.

To treat the patient along any one line alone is extremely inadequate. We can treat him by bed rest, artificial pneumothorax or other surgical procedures, but he will not take the rest or treatment as advised unless

Dr. McKone is medical superintendent of Western Counties Veterans Lodge, London, Ont., where this experiment in rehabilitation is proceeding.

mentally at ease. In order to treat the patient from the medical standpoint, he must be taught not only what tuberculosis is and how to take the rest cure, but his social problems should be settled, for example—relationship with family and friends. The family should be educated along such lines as the part that should be played by them in treating the patient. Far too often the patient carries heavy burdens in regard to social or domestic problems, when he should take advantage of the doctor, nurse, padre, or social worker, any of whom are only too willing to listen to his troubles and give advice and assistance whenever possible.

Again, in order to be free of anxiety, the economic problem is considered. With veterans this problem is not nearly as acute as for those for whom the financial assistance given is considerably less than that given to the D.V.A. patients. A patient is improperly rehabilitated when he requires work in excess of his physical capacity in order to sustain an economic status compatible with life as a good citizen. Vocational guidance is necessary to assist the patient in choosing a suitable occupation.

This briefly describes the various links in the chain called "rehabilitation." If there is a flaw in any one link, or if one link is absent, we do not have rehabilitation. To date we must admit our chain has not been flawless. Most of those interested in tuberculosis realize this and it is now being made possible to complete the chain to build up rehabilitation in the true sense of the word.

In-sanatorium Rehabilitation

In the past, there has been a hard struggle by various sanatoria authorities to establish a form of education or rehabilitation with the sanatoria. Even to this day in-sanatorium rehabilitation is not yet as complete as desired in most hospitals. It is planned to interview patients shortly after admission, or as soon as they are well enough, regarding their future. In other words, rehabilitation is built up in the minds of the patient within a very short time following admission. In my own experience, there appeared to be a definite difference in attitude of the patients towards the fact that they were hospitalized in a sanatorium, when plans were discussed, even briefly, for their future during the first medical examination. These patients appeared to be more relaxed and self-assured than the patient who did not have discussions of a similar nature.

Post-sanatorium Rehabilitation

The central theme of this paper is the post-sanatorium rehabilitation period—that period which is usually spent or wasted by the patient at home. It covers the period from the time the patient leaves the sanatorium until he is physically, mentally, socially, economically, and vocationally adjusted to take his place once again in society. At such a centre as Western Counties Veterans Lodge, situated entirely separate from a sanatorium, a home is provided for patients (entirely male veterans at the present time) at which recreation, studies of all kinds, medical care and supervision, and particularly prevocational exploration, are made available. At the same time, it is essentially free of the sanatorium environment. In order to accomplish rehabilitation as we see it, it is necessary to have a staff consisting of doctors and nurses, rehabilitation supervisor, chief educational instructor to act as principal of education, as well as a qualified teaching staff for the purpose of teaching academic, commercial, and technical courses. To cover the other important phases of rehabilitation, we require the services of occupational therapists, psychiatrists, psychologists, medical social workers, and padres. The part played by each member of the staff is quite obvious.

Rehabilitation Case Conference

Patients are screened by means of a series of casual interviews with the various members of the rehabilitation team during the first week following admission. The week is climaxed

by a case conference, at which the staff discussed each patient from the various aspects of rehabilitation. Those presenting little or no problem are in the minority.

It is readily understood that it would be impossible to solve each individual patient's problem concerning the future in one interview or conference. During the second week, each patient is assigned to a course of his own choosing and, after that, prevocational exploration commences.

It is possible now, and will be more so in the future, to have facilities which will assist the staff to assist the patient to explore himself academically, commercially, or vocationally. Gradually a relationship is building up between the Lodge and industry, and other groups of business and education which will assist us where necessary.

A man is considered rehabilitated from the vocational aspect when he has discovered his natural talent or ability and developed it to the extent that he is ready for employment in the field for which he is best suited and qualified. When this achievement has been accomplished, it is reasonable to rest assured that the person concerned will be able to complete his daily tasks with efficiency and ease, while at the same time he will enjoy his work. His work should be like a hobby. His possibilities of advancing himself in any particular trade or profession are certainly not lacking.

The work being carried on is not without pitfalls. However, it is hoped that many of those who otherwise would constantly be misplaced vocationally, will ultimately reach a state of physical, mental, social, economic, and vocational security.

Selection of Patients

All patients admitted to the Lodge are male veterans who have suffered from all stages and forms of tuberculosis and who require rehabilitation. They may have come from sanatorium directly, or possibly they have been discharged from sanatorium for several months and may even be holding a position, but require treatment along one or more aspects of rehabilitation as defined. This may be indicated by loss of appetite or weight, due to lack of interest in the type of work or place of work, or even due to the heavy nature of the work. Such a situation might easily result in relapse of the disease. If it is possible that further rehabilitation will prevent a relapse, admission is imperative.

Location of Buildings

Western Counties Veterans Lodge is half a mile south of Westminster Hospital, in London, Ont. It is hidden from the highway by trees in the summer. There are eleven buildings. Eight pavilions provide living quarters large enough to house twenty-four patients comfortably. They are arranged to form the upstroke of a "U"—four pavilions on each side. At the curve of the "U" there is a large brick recreation hall equipped for gymnasium or theatre. The administration building and workshop building comprise the remainder. In the hollow of the "U" is a ravine which serves as an outdoor amphitheatre. At the open end there is a small lake. Landscaping is still slowly progressing towards completion.

Conclusion

This form of rehabilitation is an experiment which requires the cooperation of everyone both directly and indirectly connected with it.

London Free Press Photo

Comfortable living quarters

The Approach to the Patient

Editor's Note: This form of letter is addressed to each patient in the Queen Alexandra Sanatorium, London, Ont., by the director of rehabilitation, Mr. Brenton Hellyar, who, after several years of teaching, contracted tuberculosis and thus knows the problems of rehabilitation from both ends.

Dear Reader:

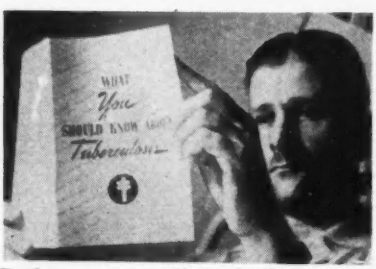
The program of rehabilitation as it works here at the sanatorium is composed of many parts. The "rehab" office does not attempt to run them all, but it helps you to become acquainted with some of the sanatorium departments which you may not know about. The main reason for a patient coming to this hospital is for health recovery. Thus the business of getting well is given first consideration. All the other things in the sanatorium which a patient may do must always take second place. For this reason, the doctor's permission must be given for each new activity which you would like to start.

Shortly after admission we want each patient to be aware of some of the non-medical services which you may wish to use. Our canteen stocks most of the needs for a patient — toilet articles, stationery, some clothing, magazines, newspapers, and other items. It is the largest sanatorium canteen in Ontario and is just like a small departmental store. There are canteen shoppers who call at your bedside to do purchasing for you. Newspapers are delivered too.

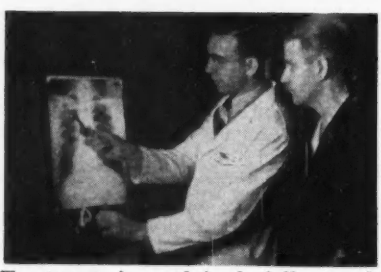
There are chaplains who come to help with your spiritual welfare. Visits are made during the week and there are chapel services each Sunday morning. The Roman Catholic Novenas are broadcast to the bedside patients from St. Agnes Chapel each Friday afternoon and so are the Protestant services on Sundays from St. Luke's-in-the-Garden. There is a double ear-phone outlet at each bedside so that you may listen to a choice of radio programs. Worship services from the chapels, entertainments from the hall, and special events from the schoolroom and dining-room are also broadcast. The patients' magazine has a San Sun Serenade each Saturday and the occupational therapy department has a Middlebrow Music Review. Both musical broadcasts are from selections requested by you and your neighbors.

The patients' library is most up to date. Best sellers are on the shelves and copies of the popular magazines are always available. A librarian calls twice weekly and you may choose as many books as you wish. The newest feature in our library is the record section. Music lovers may receive an album of music and borrow a record player, too, if desired. A patients' magazine, the *Q.A.S. Sun*, is published monthly with local news as well as health articles. The editorial staff and floor reporters are all patients.

After treatment has started and you have learned how to get along in the hospital community, one of us



Patients are supplied with literature to learn as much as possible about tuberculosis.



Treatment is explained fully to the patient so that he will co-operate knowingly.

from the rehabilitation office will call on you to inquire about your previous job. If a person may go back to that same job, with doctor's approval, it is all right. Perhaps you would like to learn more about it so that you may do the job better. Others in this group might choose to learn a new hobby. This is helpful since each of us will need some way of using our leisure time while in bed and later at home. Still other patients may find it necessary to train for a job suitable to their new health. For such as these, the rehabilitation counsellor can arrange for aptitude tests and then exploration of various occupations. Very often it is possible to start basic training in the new occupation while still in bed.

We have an Education Department with an exceptionally good school staff who teach all the public school subjects, shorthand, typing, bookkeeping, and oil painting. If your occupational choice falls in an area not covered by our school staff then correspondence courses can be arranged for you. It may be of interest to you to know that Queen Alexandra Sanatorium was the first "san" to head up such a rehabilitation program; also, that the Ontario Department of Education approves our program as a training centre for personnel in rehabilitation work.

For hobby-hungry folk, we have an Occupational Therapy Department. The therapists will help you to decide which hobby would best answer your need. Through O.T., you may receive instruction in needlecrafts such as knitting, sewing, crocheting and tatting; in leathercraft, such as tooling and carving, and how to make billfolds, gloves, belts, wallets, and handbags; in shellcraft, such as earrings, brooches, and pendants; in weaving, such as scarfs and ties. Doctor's approval is needed for either O.T. activity or for school studies, or to attend the movies on your floor. These movies are shown every second week in your own building (except surgery). The movie schedule is posted on the bulletin board giving the time when to expect the show.

Bedside instruction is given in high school subjects.

Later on in the sanatorium treatment your doctor will prescribe exercise. Physical hardening is another name for this exercise. This period usually starts with short walks, gradually increased with doctor's permission, until you may go down to the dining-room for one, then two, and later three meals. Now you may walk to the chapels for worship, to the canteen or O.T. for supplies, to the schoolroom for classes there, to the O.T. for dressmaking, or to the hall for concerts or parties. There are a few part-time jobs for those who have a two-hour work tolerance. These jobs are librarian, radio, canteen shopper, orderly, nursing, and some others. In all these exercise activities, extreme care must be taken to be sure that this new health of yours is not impaired.

When discharge plans are being arranged, each of you must realize that your treatment is only half completed. The day of discharge is a good time for you to take stock of how you have learned to fight tuberculosis. It is time to begin applying to your new life what you have

Each patient has an opportunity to learn a new hobby.

learned in the sanatorium. Especially you should plan each item concerning sleep, rest, food, and regular habits which are the essence of sanatorium life. Your clinic chest consultant will be helpful in any plan changes which you consider. Have him help you plan your life—then live your plan. Should further training be needed plans for that training will be completed by the rehabilitation department here. If you are a veteran on exercise, maybe you have been fortunate enough to have been taken on a tour of Western Counties Veterans Lodge. As you saw, it is a further phase of the rehabilitation program. In order to assist you, a summary of our findings of you has been sent to the Department of Veterans Affairs Casualty Rehabilitation Office and one to Dr. B. McKone, director of Western Counties Veterans Lodge. The casualty rehabilitation officer, if you have not already met him, will visit you at home. No doubt many of you veterans would enjoy a visit at home before entering on another phase of rehabilitation. Veterans and non-veterans come under the rehabilitation plan but so far only veterans may take further training at Veterans Lodge. Maybe you are well enough to seek a job following your convalescent period. You will know most of the details before leaving the "san." Job-hunting is easy at present. However, should difficulty arise, there is a special placement division in most of the large National Employment Service offices. The special placement staff are trained particularly for helping handicapped folk in finding suitable job placement. "Rehab" service can send a referral to special placements if you wish.

At any time during your sanatorium stay, "Rehab" is ready to help you. Should we have not called on you yet and you have some problem which we could help in, drop a note in the mail to us and we will do our best. "Rehab" service acts as a co-ordinating service to help you to get the most out of sanatorium life.

Sincerely,

BRENTON HELLYAR
Rehabilitation Service

Hazards of Flying for TB Patients

EZRA V. BRIDGE, M.D.

Editor's Note: This article is reprinted from the May, 1948, issue of the *Bulletin* of the National Tuberculosis Association (U. S.A.) with their kind permission.

"DOCTOR, should I do any flying?" Many patients with tuberculosis of the lungs want an answer to this question, because their business requires flying or they want to fly for the fun of it. Whether it is wise for them to fly depends on a number of things. Some can do it safely. The rest are facing danger.

Air on the ground is much heavier than it is a mile or two up. At sea level it exerts a pressure of fifteen pounds on each square inch of the body surface. One doesn't feel it because it presses equally on all sides. This pressure diminishes rapidly as one rises from sea level. At the top of a mountain it is much less and a mile above that it is still less. In other words. the higher one goes, the lower the pressure.

INSIDE AIR EXPANDS

A toy balloon has rubber walls that stretch. Take this balloon up in the sky and it will get bigger because the air inside expands as the pressure of the air surrounding the balloon decreases.

Many patients with pulmonary

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tuberculosis have abnormal collections of air in their bodies. A cavity in the lung represents such a collection, so do pneumothorax and pneumoperitoneum. They are major hazards in flying. They behave like the balloon. Upon rising from the surface of the earth, these collections of air will expand. They will try to occupy more space than they did on the ground. The degree of their expansion will depend on how much their walls will stretch. The air in a pneumothorax or pneumoperitoneum will occupy more space when exposed to conditions in the upper regions. There will be more of a pneumothorax or pneumoperitoneum, with greater compression of the lung above the earth than on the ground.

The increase in these abnormal collections of air at various heights above sea level is as follows: at 2,000 feet—7 per cent; 4,000 feet—15 per cent; 6,000 feet—27 per cent; 8,000 feet — 38 per cent; 10,000 feet —49 per cent; 12,000 feet—63 per cent; 14,000 feet—77 per cent; 16,000 feet—94 per cent; 18,000 feet—112 per cent; 20,000 feet—134 per cent; 30,000 feet—285 per cent.

Notice that the collection of air will become about 50 per cent larger at 10,000 feet and nearly 100 per cent larger at 16,000 feet.

Commercial planes usually fly below 10,000 feet. They might have to fly higher when crossing mountains or encountering storms. At any height, changes can be expected in all accumulations of air. The higher one goes the more pronounced these changes become. For example, the expansion at 2,000 feet is only 7 per cent; five times higher the expansion is seven times greater.

Breathing Hazards

A refill for pneumothorax or pneumoperitoneum is calculated to produce the right pressure on the lung. A bigger refill would be too much; it might do harm. Going up in an airplane is just like getting a bigger refill.

Flying is definitely hazardous for those who have pneumothorax complicated by adhesions. Expansion of the pneumothorax stretches adhesions and they may break. If they do not break they may pull hard enough to rip the surface of the lung. Air will then leak into the pneumothorax air-pocket and dangerously increase its size. Massive increase will push the heart toward the opposite side of the chest and compress the opposite lung. If respiration is embarrassed, the patient may become alarmingly short of breath, have palpitation, sudden weakness, even shock.

Some patients have pneumothorax compressing both lungs. Their capacity to breathe is much diminished. Flying for them is contra-indicated as it can well bring on severe shortness of breath and other frightening symptoms.

Pressure and Hernia

Beneath the breast bone one lung is separated from the other by a group of structures known as the mediastinum. This mediastinum has several weak spots. Through these a pneumothorax may bulge into the opposite side of the chest. This is called a hernia of the mediastinum and is not without danger even on the ground. In flight, such a situation can become exceedingly uncomfortable.

Those patients who notice discomfort after pneumothorax or pneumoperitoneum refills will certainly have greater discomfort when flying. Those who are short of breath on exertion will have more difficulty when flying. Patients who have recently bled from the lungs should postpone any thought of flying because of the danger of re-opening the blood vessel. Tuberculosis frequently produces cavities in the lungs. These, of course, contain air. In flight, this air expands. When air can escape from a cavity the danger is minimal. But often some obstruction is present. When this is so, the trapped air expands and pushes against the cavity wall. This may be great enough to tear the walls of the cavity or injure a blood vessel with subsequent bleeding which can threaten life.

To prevent serious discomfort or

damage, some patients may have to breathe oxygen through a mask when flying. Other patients will fare better if air is removed from their pneumothorax or pneumoperitoneum before they fly. Airplanes that fly far above the earth, 20,000 or 30,000 feet, are pressurized. Pumping systems maintain an air pressure inside the cabins simulating conditions much closer to the ground. Otherwise, no one could remain at those heights. Nevertheless, a few patients face danger in a pressurized airplane because the pressure in the cabin cannot be kept at ground level values.

The tuberculous patient is wise who consults his doctor before he flies.

Appalling Facts !

ELLA M. ROULSTON

In some of the sanatoria . . . wards or units have to be closed due to lack of nursing service.

Deep concern was expressed at a meeting of the Joint Committee on Tuberculosis Nursing over the fact that registered nurses were not willing to do nursing in tuberculosis.

A survey . . . last spring revealed a nursing shortage of 48 per cent in tuberculosis sanatoria.

THE ABOVE statements have appeared in *The Canadian Nurse* and an editorial of a daily newspaper. In this atomic age surely we are not holding to that old tradition of running away from the disease. Let us free this big social problem. We know that early detection of the disease brings gratifying results as statistics have proved. In Canada in 1900 the death rate was 200 per 100,000; by 1942 it was approximately 50 per 100,000.

Wherein lies the failure in the shortage of this branch of nursing? Is it because experience in sanatoria has not been included, except for a limited number, in the basic training of nurses? It is always surprising to hear graduate nurses and, especially, nurses taking the public health course say that they have not had experience in tuberculosis nursing. We feel that countless opportunities arise for nurses to be health educators and to be tuberculosis-conscious. Therefore, is it not timely to appeal to the administrative staff of schools of nursing to include sanatorium experience in the curriculum of a student nurse?

The following are some essential points that should be considered for student nurses entering a sanatorium:

1. The ideal time — preferably after vacation.
2. Strict supervision.
3. Stress plenty of rest, fresh air, outdoor exercise.
4. Regular check-up of x-ray and hemoglobin.
5. A weekly weight chart should be kept.
6. Report immediately any elevation of temperature, colds, any unusual symptoms.
7. Keep fortified with good food, vitamin pills, and other medication.
8. Negative reactors to the tuberculin test should be exempt except in institutions where immunization is provided by giving B.C.G.
9. Absolutely no familiarity with patients.
10. All supervisors and nurses in charge of the student nurse should instil in her mind a high respect for the treatment of the tuberculosis patient and banish the old concept of fear by adequate instruction as to the nature of the disease and the proper way to handle the patient suffering from it.

As has been said, a nurse is as safe working in a sanatorium as in a general hospital if she uses the proper technique, and, if she doesn't, she is not safe to work anywhere.

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Tuberculosis is an amazing study and, too, a fascinating one. Tuberculosis existed in prehistoric times and has been recognized as far back as history goes. Evidence of it was found in Egyptian mummies, notably the sixteen-year-old King Tutankamen. The lives of real people have been built around tuberculosis. So many artists, poets, novelists, and musicians have been victims of the disease. A few whom we might mention include: Jane Austen, Ralph Waldo Emerson, Nathaniel Hawthorne, Samuel Johnson, John Keats, John Ruskin, Sir Walter Scott, Robert Louis Stevenson, and Chopin.

Hippocrates (460-367 B.C.) defined phthisis as an ulceration and suppuration of the lung and he believed it to be due to the following four causes: Unresolved pneumonia; discharges from the pharynx entering the lungs and becoming stagnant; blood spitting; empyema. Down through the centuries the names of outstanding men who did a great deal in investigating the disease are emblazoned on the pages of medical history and their work is the foundation. Since Dr. Robert Koch, in his discovery of the *Tubercle Bacillus*, in 1882, Dr. Edward Trudeau, as pioneer of the modern sanatorium treatment, 1884, and Dr. Wm. Roentgen in the beginning of the x-ray in 1895, great strides have been made in the prevention, radiology, and surgery of this disease.

We wish to place on record the splendid work done by our Canadian Tuberculosis Association, founded in 1901, and the information furnished in the free distribution of periodicals. Everyone should be acquainted with the unique story of the Christmas seal which started in 1903.

One matron said that when tuberculosis nursing gets into your blood you have to stay with it and it is true. You have to work with the tuberculous patient from a psychological standpoint as well as a physical one to find out what a satisfying service it is. It is a curable disease if adequate treatment is given at an early stage. What a thrill it is to see patients after weeks and months in bed leave the sanatorium and take up useful lives again. What a different picture it was seventy-five years ago!

Tuberculosis Training Needed

E. L. Ross, M.D.

TUBERCULOSIS is still the greatest cause of death between the ages of fifteen and forty-five. Hundreds of patients are on treatment all the time and since the care of tuberculosis patients is mainly nursing, the nursing profession should have a vital interest in this field. No other disease causing as much illness, requiring as much nursing, and of such public health importance is given as little attention as tuberculosis during the nurse's training. This lack of education, understanding, and interest is limiting the effectiveness of the whole anti-tuberculosis campaign and is mainly responsible for the fact that many with active disease are in their homes infecting their families instead of being on treatment in sanatorium. This is the reason that treatment and segregation is not keeping pace with the case-finding program and is thus diluting the benefit of preventive activities.

The present-day sanatorium is a hospital where modern and progressive scientific treatment is being carried out but we rarely find a nurse who has had any special preparation in tuberculosis nursing. The only means of overcoming this is through knowledge and knowledge should be gained by

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providing the nurse in training with teaching instruction, and experience in tuberculosis care. Nurses may have had a few lectures in tuberculosis during their training period but they lack clinical experience and, to my mind, the only means of obtaining this is by the affiliation of all student nurses with a sanatorium for an adequate length of time. To make provision for this, a period of affiliation and teaching should be incorporated into their regular training curriculum.

Nurses, and to some extent doctors also, have a fear of tuberculosis but this phobia can be overcome by proper understanding. In the first place anyone who has chosen the high and commendable duty of caring for the sick must accept the fact that they are subjecting themselves to health hazards not encountered by those not associated with sick people. It has been shown that the incidence of nurses breaking down with tuberculosis in a sanatorium is no greater than in a general hospital—in fact it is rare for a trained nurse in sanatorium to develop the disease. Over the six-year period from 1938 to 1943 no graduate nurse at Ninette, Man., developed a tuberculosis lesion. In general hospitals about 1 per cent with a positive tuberculin develop some manifestation of tuberculosis, and 3 to 4 per cent of the non-reactors. The reason that the sanatorium is safer for trained personnel is because all patients are considered infectious, or potentially so, and proper precautions are constantly taken. In general hospitals patients with unrecognized tuberculosis on treatment for some other condition may be infectious and the usual safeguards are more liable not to be taken.

Some Problems of the Training School

M. ADELAIDE NUTTING

Editor's Note: In the **December, 1908,** issue of *The Canadian Nurse* a very interesting article was published which the late Miss Nutting had read before the American Hospital Association. We have reproduced the greater part of it here that you may see how her penetrating analysis of the problems existent in that distant day are still with us. Many of the remedies she proposed have not yet been adopted in the forty years that have elapsed. Read it carefully. You will enjoy it.

Called into existence as a means of improving the care of the sick in hospitals, the first training schools were established, not by the hospitals, but by groups of individuals outside of them, who provided funds for the maintenance of the schools, and entered into an agreement with the hospitals to give the pupils certain definite teaching, training and experience, in return for such services as they could render for the sick. Although entirely subordinate to the regulations of the hospital in all that concerned their work, the pupils were, nevertheless, under the direction of an independent body in matters connected with their teaching, training, conduct, and discipline.

In the first school for nurses (established in 1860 by the Nightingale Fund at St. Thomas's Hospital, London) this body so interpreted its functions that it not only paid for the board of the pupils and for their uniforms, but paid also a part of the salary of the ward head nurse, as compensation for her service in teaching the probationers.

It will thus be seen that the organization of these early nurses' schools was in some ways similar to that of the medical school, with this essential difference, however, that the medical student paid for his education and training, and the pupil nurse was paid to receive hers.

In the improved condition of the hospital

brought about by the school; in the efficiency of this method of caring for the sick, and its comparatively low cost; in the obvious advantage to the hospital in having entire control of the pupils, and the ease with which such control could be secured, we find a situation leading readily to the incorporation of the training school into the hospital. The logical outcome of this is expressed today in the thousand or more training schools which are an integral part of the hospitals in this country, and governed by the same authority.

Today, the school has no life of its own, but is shaped and moulded to the needs of the hospital and restricted by its powers. In numbers and character of pupils, in purpose and direction, in conditions of living quarters, food, recreation, in hours on duty and hours off, and, finally, in teaching and in training throughout, in substance, method, teachers and equipment, the school takes what the hospital determines it shall have.

That several of our hospitals are governed in a liberal and enlightened spirit, and thought given to the welfare of the pupil nurse, is a matter quite irrelevant from the main issue, which is the position of the training school in its relation to the hospital. It stands unique as an educational institution of high importance, practically owned by another institution, which profits by the industry of the pupils. Under good conditions the results may be good, often even excellent; under other conditions, they may be, and often are, unspeakably bad. Under any or all conditions, the question to ask is: "Does this system produce the best results? Is it a just arrangement for hospital and pupil? Is it the best that we can do?" And the answer to this is that we do not know, because we have not as yet really tried any other.

In the meanwhile it is quite certain that the present relation between hospital and training school gives rise to many and difficult problems. The one person to whom these problems present themselves in their most pressing and perplexing aspects is the executive officer who holds the double office of superintendent of nurses and principal of the training school. Deeply loyal to both, seeing clearly the needs of each, concerned in meeting them adequately and in carrying out the purposes of each to the fullest possible degree wherever they conflict, she is between the upper and nether millstone.

Such a conflict appears at the very outset in the necessity which exists for selecting the pupils in accordance with the immediate needs of the hospital, rather than with suitable standards of requirement for the general work of nursing. I know of no training school, large or small, where the number of properly qualified women applying for admission is large enough to meet the needs of the hospital, and by that I mean to do the actual nursing work in it.

And by properly qualified women I do not mean highly educated women (desirable as they are), nor do I set up any severe standard of requirements. I mean, simply, women of good, thorough English education, of suitable age, good character, physically and mentally sound, and temperamentally able to stand the strain of hospital training and the subsequent work into which that training leads. You will agree, I am sure, that nothing less than this is a safe foundation on which to build any professional or vocational training, yet out of the applicants to our training schools the number that fully meets these moderate requirements is small. A few in the more prominent schools exceed them, but I say, without hesitation . . .the number of those who are properly qualified falls considerably below the number of pupils needed by the hospital. Now, because this small number of good and promising candidates cannot do the required work, it becomes necessary to add to it (to "keep up the numbers," as the phrase goes) by a larger or smaller number of others who fall below standards in varying ways and degrees.

Although the larger and more prominent schools, where more ample opportunities and advantages are offered, do attract the larger number of desirable pupils, yet question any one of these and I think you will be assured that there are never nearly enough really good candidates, and that the needs of the hospital must always be met by including the less worthy. And if this is true of the large schools, what might we naturally expect of the smaller, where the opportunities for suitable teaching and training are in various ways inadequate?

This lack of good, or of any, applicants for admission to some training schools is of grave import. It seems ominous to those who, familiar with the training school problem as it presses daily, can see no way out of the bewildering and complicated state of affairs. Yet it may not be an unmixed evil if it induces us to give serious and unprejudiced

study to the situation, and get down, if we can, to the root of the matter. When we can be quite certain of the cause, or causes (for there may be several), we can then discuss the remedy intelligently and profitably.

The rapid increase in the demand for pupils for hospital work has practically doubled within a few years, owing to the great activity in the line of hospital building. This does not seem to suggest any falling away in students as such. What we need to observe is that, notwithstanding the very large number of pupils in the schools, there are still not enough to meet the needs of the hospitals.

Meanwhile colleges for women have grown and multiplied . . . The greater prosperity of the people of this country has made it easy for women to enter college today, whose sisters of twenty-five years ago might have been glad to get for little or no expense what the training school offered. It is possible that the colleges might serve as a means of enlightenment. They might, it is conceivable, point to the long list of waiting candidates for entrance each year, and say that there is apparently no lack of good women seeking education, and that if we cannot find them — or, rather, they will not find us — it may be true that we are not offering them conditions which attract them to us. In other words, they like what the colleges offer, and will not have what the training school offers. Yet one would suppose that nursing would be just the work to attract the thoughtful, healthy-minded, educated person, and especially where the training for it could be obtained free of all cost. One is inclined to remember the saying that people do not value what they do not have to pay for.

There is another and quite different way in which the status of the school may be affected. That is when the accommodation for pupils is insufficient for the number required to do the work in the hospitals. Here we have a defect which cuts both ways, and affects the welfare of both hospital and school. Hospitals have a way of outgrowing with extraordinary rapidity the provisions made for nurses, and of adding department after department of new work, without at the same time realizing that each new development of hospital work calls for some corresponding increase in the nursing staff. Hence we find in many schools the superintendent of nurses calling attention to lack of quarters for pupils, and asking for more, stating that her pupils are overworked daily because she has not room for as many as the hospital needs. This is a very common complaint. It affects steadily and disadvantageously the character of the pupils' work. It usually eliminates all possibility of study, and tends ultimately to produce the disheartened and discouraged worker. And it is those physical and nervous breakdowns among pupils, which, in addition to the loss of just so much human efficiency, stand particularly to the discredit of the training school, which, above all places, should set standards of healthful and well-ordered living. Such conditions often militate strongly against the school in its ability to attract desirable applicants. "I will not send my daughter to that school; they will work her to death," is the not-uncommon criticism of certain schools, where there is failure on the part of the hospital to provide abundant and suitable quarters for its workers.

When such a situation continues, the place loses all characteristics of a school. The overcrowded student can never profit even by the best teaching; she cannot study; frequently she cannot even listen intelligently. To all intents and purposes the school has for her ceased to be a school. She is no pupil; she is a worker, whether efficient or inefficient.

Thus the health, welfare, and instruction of the pupils is seen to depend upon the hospital; and since the conviction is held, and strongly, that all pupils must live in quarters provided for them, usually within the hospital precincts, and under its control, no remedy for this state of affairs seems likely to come. The pupil, even if she lives in the same city, cannot live home and go to her school daily, as is customary in other educational institutions, but must occupy the space in the nurses' quarters which would at least provide room for one more worker for the force. There seems lack of true economy in this method, but it is, of course, so greatly for the advantage of the hospital, and so apparently essential for its smooth running, that any other system will not easily find favor.

It is when we approach the actual education of our pupil and attempt to carry out the promises which have been made to her, that the resisting power of the hospital becomes more and more strongly felt, and the enormous difficulty with which it meets even the least of its obligations in this respect is clearly seen. There is no place in its strenuous scheme of life for the machinery of a school. All the space, the effort, the means

which the hospital can provide are needed to carry out its immediate purpose, which is the care of the sick, and any scheme of education must, of necessity, take a secondary and insignificant place. A school, to fulfill its functions, cannot take such a place; it calls for teachers, classrooms, equipment, and every subject offered in the curriculum needs these to a greater or less degree. Some subjects, to be taught at all, require a laboratory as well. The teacher is presumably a person specially prepared to teach, with ability to handle certain subjects efficiently, and with time to meet his class regularly, to know his students, and to be interested in their advancement. How far is it possible for the hospital to provide anything of this nature? A good proportion of the teaching given is that comprised in a series of lectures, given gratuitously by different physicians of the staff. That they are cheerfully given, and that much of such teaching is excellent, as far as it goes, does not essentially alter the main facts, which are that such teaching is dependent in its character upon the particular views of that particular physician as to the education of nurses, and upon good-will and circumstances as to regularity and system. It has no stable character of its own. It may or may not cover a certain definite ground. It may be good, even excellent, or it may be worthless as teaching. The school has little power to choose which it shall be. With neither means to pay for suitable teaching, nor freedom to choose the teacher, it must accept whatever is within its reach.

Turning from the teacher to the subjects taught, this matter also is governed by the ability or will of the hospital to provide. Although the teaching in most of our schools is elementary from beginning to end, yet there is the power to restrict this teaching, or to reduce the ground covered in a certain subject to the barest outline.

As to classrooms and equipment, there is in hundreds of schools not the slightest pretence of either. The classroom may be the screened-off end of a sitting-room; it may be the dining-room; it may be any room which can at short notice be supplied with chairs and table and blackboard. In scarcely any school is there a classroom large enough for the entire body of pupils to be assembled together. When we come to equipment, material for teaching, such as microscopes, maps, charts, photographs, models, and specimens, there is such a painful void that one sometimes wonders how the teaching can be carried on at all. It is almost inconceivable that a body which takes upon itself the function of a School Board as well as a Hospital Board should so lightly view its responsibilities.

It is generally conceded that teaching given in the evening, after a day of hard physical effort, is of very limited value. Yet, until very recently, nearly all of the teaching in training schools was given in the evening, and the eight o'clock lecture was the educational event of the week. I am happy to say that there is now a distinct effort being made to bring classes and lectures forward into the afternoon.

As to the practical teaching and training in the wards, it will probably be said that here at least the hospital provides amply for all needs of the pupil, for even at the minimum she must work in the wards or other hospital departments eight hours daily; so that, while two hours weekly is the average, and three the maximum for theoretical teaching, from fifty to sixty hours of ward work are required weekly of the pupil, even under the easiest conditions. The suggestion that in any of our training schools for nurses there is an undue proportion of theory would be ridiculous, if it were not pathetic. We are all mentally lazy, and it is often true that the pupils will say they love their active work in the wards, and do not enjoy their study; but that does not alter the fact that they need the study, whether they enjoy it or not.

But how about this teaching and training in the ward, which we have agreed is so valuable? If it is so important, it is, of course, carefully carried on by highly qualified nurses, specially prepared to teach over the patient the most skilled and perfect methods of nursing. The young pupil must be taught how to observe and record every trifling change in the patient's condition, and what action such a change calls for. She must be taught every process, then practise each assiduously, under criticism and supervision, until it can be performed with that ease which is the final perfection of skill; and then she must be taught further under what conditions the process itself must be varied, adjusted, modified to suit the different temperaments and needs of the sick.

Seldom is anything even faintly resembling such a method of teaching carried out in any complete and satisfactory way in our

training schools. The pupil is in the ward to do the work, and to do as much as she can possibly accomplish in a given time. In many hospitals, and especially in certain departments, she works under pressure every hour; and not only has she no time to be taught, but the head nurse of the ward has no time to teach her.

In certain small hospitals all of the teaching in both classroom and ward is done by the overworked executive head of the hospital. So that this invaluable field of teaching, the hospital ward, becomes the place where the pupil passes through a succession of experiences and performs over and over again certain acts; but its use as a place for definite study — observation, instruction, and suitable development — is little to what it might be.

The question of the length of training of the pupil is so important that a brief consideration of the matter should not be omitted. Those who have the best right to know how and under what conditions nurses should be taught and trained believe that it is not possible to give the average pupil a full, complete and thorough training in less than three years. The applicant of today is a very different problem from the mature woman who entered the training school fifteen or twenty years ago. She differs from the earlier in having a less careful home training. She does not bring to the school, whatever her other qualifications in education, in natural ability or personality, the knowledge of domestic affairs which was usually possessed by the applicant of twenty years ago. Nor has she met any of those home responsibilities which we still consider one of the most valuable qualifications which an applicant can bring.

For these reasons alone the applicant of today needs a longer and more careful training to bring her up to the standard. But to this fact we must add another, and one not sufficiently recognized, that there is a wide difference between the requirements which the profession of nursing made of its members twenty years ago, and the professional requirements of today.

Twenty years ago, our pupils, as they left the training school, had practically but one field of work open to them. Today not only have many new avenues for the nurse opened up that were practically undreamed of at that time, but the familiar ground of private work has itself so developed as to call for a more thorough, varied, and longer training for the pupil. As to institutional positions, they grow in number and importance not only the superintendents of hospitals and training schools, but those who fill the offices of assistants, supervisors, and head nurses in them. The call for nurses to fill such hospital positions is ceaseless, and we cannot meet it adequately until we can attract into our training schools more women of thorough education and the serious and earnest purpose in life which it usually brings.

Nor does the call for the graduate nurse cease when the institutions and private households are supplied. It comes even more clearly and imperatively to many nurses from the sick poor in the crowded quarters of our cities; from our factories and department stores; from our public schools, and from numberless other places where the stress and strain of our modern life calls for trained and skilled helpers imbued with the spirit of service to their fellows.

It needs no argument of mine, I am sure, to convince you that the foundation for any of the various kinds of work which have been touched upon here needs to be broad, strong, and carefully laid, and that no brief or limited preparation will suffice. In saying, however, that it cannot well be given in less than three years, I would not be understood as agreeing that a course of such length should be offered in the majority of hospitals. Unless a hospital can provide for a full training in every service, it is not justified in keeping the pupil for three years.

In this attempt to place before you some, at least, of the problems with which the training school is confronted, I am led to believe that they are all mere aspects and phases of one single problem, and that problem is the relation of the hospital to the training school. Familiar as we all are with the present system, it is not easy to entertain the idea of anything different. Yet there are those who feel that, in the best interests of both hospital and training school, whose reconstruction of that system is necessary, much of the teaching, especially all of that fundamental work included in the preparatory course now given in the hospital, should be given outside of it, in a central school, which could do for a number of hospitals what each one is now trying to do for itself. This central school should take upon itself the direction of the education and the responsibility of arranging with different hospitals for the practical training of the pupil in all the various services. Such central

schools could, in course of time, help to solve the problem of nursing in some of the small hospitals.

I should like to add my personal belief that the pupil should pay for her training straight through, that she should be more independent of the requirements of the hospital, which, in some departments, should be partly met by salaried workers.

I am by no means presenting new ideas to you in these suggestions. Most of them have already been made by a good many people. The need of such a central school was admirably presented by Dr. Francis Denny in June, 1903. An article by Dr. Oldfield, in the *Westminster Review* a few years ago, advocated the granting of degrees. I confess that nursing seems to me as worthy of a place in the scheme of the university as any art or science in it.

I have tried in this paper to lay before you as faithfully as I could some of the difficulties with which our training schools are contending, which are apparently the inevitable result of the present relationship between school and hospital. This is no question of doctor *versus* nurse, or of hospital *versus* training school; each is essential to the other. The question is, what is the very best that we can do for our training schools? The various classes of people and the institutions in the community which have come to lean upon the trained nurse, and to be dependent upon her services, require of us that we should, in our teaching and training, put her in the way of developing those services to their ultimate power and usefulness.

In the Good Old Days

(*The Canadian Nurse, December, 1908*)

"A reception was tendered to Miss Mary A. MacKenzie, Chief Lady Superintendent of the V.O.N., during her recent visit to Saint John, N.B. Miss MacKenzie gave an inspiring address, describing the work of the nurses in the district hospitals. Her remarks were attentively listened to by . . . a large number of citizens present and much interest was shown in the proceedings."

Remarks addressed to the class graduating in the fall of 1908 by Miss Nora Livingston, lady superintendent of the Montreal General Hospital, echo today with a realistic ring. She said in part:

"For you the day of independent activities is at hand; yesterday you were pupil nurses — today, no doubt, you speak of yourselves as of the profession. Remember, labels are perilous things and exact of us who accept them very serious conditions. What is a profession? The dictionaries define it as — a 'vocation,' a 'calling'— requiring a learned education. I trust that for all of you the calling is by voices which commit you to a creed of conduct such as that to which the best of our profession aims; it exacts not only purity, but honor and self-discipline."

"The thermos bottle (which is now to be had at all drug stores) is really indispensable to the trained nurse or to the mother caring for a baby. If you put anything in it this wonderful bottle will keep it hot for twenty-four hours . . . Think of what that means for you!"

"Kincardine has a hospital. Mrs. Gualco, one of the residents of Kincardine, invited the Mayor . . . and the Council . . . to meet at her residence on November 5 and presented them with a valuable property, situated just outside the town, on an elevation overlooking Lake Huron, and consisting of a site of two and a half acres, with valuable buildings. Mrs. Gualco at the same time endowed the hospital with $25,000, and said when engaged in making her will recently she had determined to give the hospital during her lifetime rather than wait till her death, so losing many opportunities to relieve sickness and suffering. The Mayor was scarcely able to express the surprise and gratitude of himself and the citizens at this magnificent gift."

"At the graduation exercises of St. Michael's (Toronto) Hospital . . . ten nurses, who had successfully passed through the course, became graduates of the hospital. After the opening prayer, each nurse had her name called, and tripped up to the dais to get her diploma and medal, with a word of congratulation from His Grace (Archbishop McEvoy). This was the first time that medals have been given with the diplomas, and the innovation gave great pleasure."

PRIVATE DUTY NURSING

Contributed by the Committee on Private Duty Nursing of the Canadian Nurses' Association

In Support of the Private Duty Nurse

DOROTHY THOMAS

THERE SEEMS to be a tendency on the part of many nurses in the institutional field of nursing to feel superior to the private duty nurse, both in ability and in importance. This is not right, and does not make for harmony. I believe that the right private duty nurse at the right time hastens the patient's recovery and sometimes saves a life.

Because a special nurse occasionally has a few minutes to sit quietly and knit or read, it should not be assumed that she is lazy and is not doing her duty. One of the values of a special nurse is to assure the patient adequate rest. Over-nursing is not *good* nursing. One sometimes hears of a nurse who wears her patient out with nursing care, in her desire to be a little better and do a little more than the nurses on the other shifts. If all three vie with one another for supremacy, the patient may suffer.

Sometimes the chief value of the special nurse is the psychological effect. Perhaps the patient is recovering from a long and serious illness and her nerves are frayed. The important duties of the nurse lie in stimulating interest, finding new means of entertainment, taking the patient for walks or to sit in the sunshine; this cannot be called luxury nursing.

I have heard nurses say, "I would be bored with only one patient." Could it be that they would be *afraid* of the responsibility a special nurse is expected to bear? A nurse has not truly nursed until she has gone out into a home, maybe in the country, and taken care of a critically ill patient; having to make quick decisions, to rely wholly on her own judgment and resourcefulness; having to cope, not only with the patient, but with anxious relatives.

* * *

Is the student nurse of today being given sufficient responsibility to equip her for the job she is expected to do after graduation? I have done both institutional and private nursing and know the satisfaction that comes from each. In the institutional field there is the satisfaction of doing many things wrapped up in one big job. The satisfaction found in private nursing is a more personal thing — the joy of seeing health and even life restored, and knowing that you played an important part in bringing about that restoration. There is need for workers in all fields of nursing; let us all pull together for the common good.

Miss Thomas carries on her good work in Chatham, Ont.

Stubbornness is adolescent and in maturity should be abandoned, or transformed into determination to be used only for constructive purposes. — *Selected*

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Tuberculosis in Waterloo County

ANNE C. BALLANTYNE

FREEPORT Sanatorium is situated in Waterloo County, Ontario, on a hill overlooking the beautiful rolling countryside. It is comprised of 158 beds for tuberculous patients with staff and equipment for caring for these patients. Waterloo County is not unique in the treatment and care of its tuberculous patients or in its anti-tuberculosis campaign, but this year there have been definite advancements made to further this work.

As nurses, we are first mainly concerned with the program as it affects our student nurses, and nurses as a whole. We, in sanatoria, are a large field calling on the various training schools to supply our demand for graduate nurses. In return for this we feel we would like to offer something toward the education of the student nurse as our contribution for professional services received.

We are planning to take a number of students from the hospitals of our district—St. Mary's Hospital, Kitchener; Kitchener-Waterloo Hospital; General Hospital, Galt; General Hospital, Guelph, and St. Joseph's Hospital, Guelph, for an observation period of two weeks. The number of students will of necessity be small, due to shortage of nurses in general hospitals and also due to our own available living accommodation. Up to this time we have lectured in the classrooms of the various hospitals mentioned but, without the practical application and experience, we do not expect it to make a lasting impression.

Under our new program, the students will see the actual treatment of the patient on the wards and in the treatment rooms during their two weeks, with lecture hours during the day following up what they have observed. We will have a supervisor in charge of these students, who is qualified and has had adequate experience in tuberculosis nursing. She will supervise them while on the wards and will also direct their course of nursing lectures. The medical and surgical aspects will be covered by our own medical staff.

We hope through this observation program to allay the fear of tuberculosis which has grown up in the minds of so many — both lay people and nurses—due mainly to lack of knowledge. We all fear that of which we are ignorant, more than something of which we have definite knowledge. As a result of this instruction our students, who come to us for direction and information, will go out to their home schools and communities as teachers, and anti-tuberculosis work will be furthered in many districts.

To date, only nurses who have a positive tuberculin skin test are eli-

Miss Ballantyne is superintendent of nurses at the Freeport Sanatorium in Kitchener, Ont.

gible for duty in sanatoria. That means they have, at some time, been in contact with a tuberculous person and have built up some immunity to the disease. In this way we feel they are better able to fight off the disease when they come directly in contact with it, as they may in sanatorium. All our personnel, of course, are x-rayed every six months, as is the ruling for positive reactors. For our student program, we are only prepared to take students with a positive skin test and those students who have had B.C.G. with a satisfactory "take," making them positive reactors. B.C.G. has been given to all negative skin test reactors among student nurses in the hospitals, before mentioned, who were desirous of having it. As a result of their very wonderful co-operation many more students will be able to come to us for their observation period.

We propose to continue our B.C.G. program for student nurses but, beginning with the next class who entered training this fall, we feel it would be desirable to have it given during their probationary period, before they are contacting patients on the wards. In this way they would have an opportunity to build up a desirable immunity.

Our sanatorium was opened in 1916 for the isolation and treatment of tuberculosis patients in Waterloo County. Clinics were established for contacts and those with symptoms. Provision was made for free x-rays at our sanatorium. In 1942, industrial surveys were begun in Waterloo County, with follow-up work and x-ray of contacts. Community mass surveys were begun in 1945, in Waterloo and Kitchener and South Waterloo County; the rural area was covered by a mobile bus x-ray unit.

This year we feel great advancement has been made with the installation, in all three of our local hospitals in the county, of camera x-ray units. Already patient admission x-ray programs have been set up. These units were purchased through the donations made by industries during our Christmas seal sale. The upkeep and maintenance of operating these clinics will be paid for from this same fund. This drive in Waterloo is very capably handled by various ladies' hospital auxiliaries of the sanatorium centralized through their Central Council.

In this way our student nurses will be protected from exposure to an active case of undiagnosed tuberculosis admitted to the general hospital for some other reason, and proper protection will be given those in contact with these patients.

Permanent out-patient clinics will be set up in these hospitals for use in addition to admission x-rays. These clinics will be operated one-half day a week in each hospital by our sanatorium staff. The films will be read and reports sent out from the Freeport Sanatorium. Any abnormal shadows appearing on the miniature film will be further investigated by having the patient come to the sanatorium for large films and complete check-up. Probably about 10 per cent of the total will require further investigation.

Those who will be x-rayed at these hospital stationary clinics would include tuberculosis contacts, high school students, immigrants, industrial groups. Those industries which, up till now, have been tuberculin testing their new employees, will now send each for x-ray only. The aim is to have a pre-employment x-ray, followed in three to five years with a follow-up x-ray. The x-ray will be within easy reach of all. The new employee need only be away from work approximately one hour. There will be no direct cost to the employer but he may make a donation at Christmas if he thinks the service provided to his industry is worthwhile. These x-ray clinics will be operated by appointment only, to assure the employer that his employees will not be kept waiting needlessly.

In summing up this information we feel that student nurses and all nurses who are situated in Waterloo County are indeed fortunate to have the opportunity of having double protection against tuberculosis.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Home-making — A Rehabilitation Project

A. EDITH FENTON, M.B.E.

IN A MODERN tuberculosis hospital are found many men and women from widely differing backgrounds and vocations: men and women with long established trades or professions; teen-agers still in the process of education but with cherished ambitions; housewives and mothers, and young folk who hope to establish homes.

The modern physician takes all this into consideration in planning treatment. A goodly number can return to former occupations but some must learn new ways of earning a living. All can benefit by the educational facilities available during treatment, whether in learning a new trade, developing cultural interests, or in just trying to be a better man at the old job. Take a housewife for example —what a variety of new and interesting things she may learn in order to make a success of that all-important job of being a homemaker.

A NUTRITION COURSE

Last year, at the Mountain Sanatorium, Hamilton, Ont., it had been hoped that a home economics instructor might be employed on the educational staff. As this was not possible, an approach was made to the local Red Cross for assistance. The appeal met with a gracious and far-seeing response, and their nutritionist, already busy with many projects, set to work.

A simple course in nutrition was planned, in collaboration with the radio director and the public health nurse on the sanatorium staff. It had nothing to do with the fact that the listeners had tuberculosis, and this was never referred to, advisedly. A mimeographed booklet on "The A.B.C. of Family Feeding" was prepared by the nutritionist to get a personal link between herself and the patients, as her time was too limited to visit them personally. The radio department, public health nurses, teachers, and others stimulated interest among patients.

CONTENT AND PAMPHLETS

Eleven talks and interviews were given over the sanatorium radio, which is a public address system with ear-phones for each bed. The importance of food in building and maintaining a healthy body, balanced meals and menu-planning, selection and care of foods, diet for well, expectant mothers, feeding the child, and the digestion of food were dealt with in a most helpful manner. Emphasis was placed on translating this knowledge into everyday healthful living. Following each weekly talk, certain suitable pamphlets (usually government) went out to the patients.

Miss Fenton has had wide experience in public health nursing and put this knowledge to excellent use at the Mountain Sanatorium, Hamilton, Ont.

The monthly Red Cross *Nutrition Bulletin*, prepared by the nutritionist for community use, was also sent to those who notified the public health nurse of their interest and who were listening to the talks. As patients have been discharged, the Red Cross Nutrition Department has made an effort to contact them and to try to interest them in nutrition activities in their home communities.

An Encouraging Response

Patients were invited to send in their names to the radio studio if they intended to seriously listen to the talks so that the mimeographed booklet, pamphlets, and Red Cross *Bulletin* might be sent to them. About 150 indicated their interest and, since the completion of the course, some new patients, hearing of it from old patients, have asked if they might at least have the printed material. It seems right that some men were included for, after all, they eat too. Considering the number of men who "bach it" or eat in restaurants these days, an increased nutrition consciousness is much to be desired. Even some staff nurses and teachers asked for the literature.

Patients confined to bed are excellent listening material and are receptive to suggestions leading to regained health. Although it is impossible to measure the full value of such an effort there is reason to believe that some measure of influence may be carried into many homes, and make a modest contribution to the better health of our people.

Part of Rehabilitation

Much is heard of the rehabilitation of the tuberculous. Many men and women are benefitting today by courses of study and apprenticeship schemes leading to suitable occupations for the earning of a livelihood. Because of the large group of housewives and housewives-to-be who are "taking the cure," the idea grew that various aspects of home-making might well have a place on the rehabilitation program.

In addition to the nutrition series just described, and which it is hoped may be repeated and extended, the Mountain Sanatorium has a very successful dressmaking course that carries on throughout the year, and it is hoped that a radio series on home decoration may be given in the near future.

Pamphlets may be obtained from the following sources:

1. Nutrition Division, Department of National Health and Welfare, Ottawa.
2. Marketing Service, Dominion Department of Agriculture, Ottawa.
3. Milk Foundation, Toronto.
4. Child and Maternal Health Division, Department of National Health and Welfare, Ottawa.
5. Evaporated Milk Association, 307 N. Michigan Ave., Chicago, Ill.
6. "Junket Folks," Chr. Hansen's Laboratory, Toronto.

Lullabies

A nurse at Vancouver's Children's Hospital has made her bedtime lullabies pay off in more than sleep for her tiny patients.

Inspired by her love for the sick and crippled youngsters, Elizabeth Clarke, R.N., composed a song while on duty in the ward.

It's entitled "Blue Bird on Your Window Sill" and is already on sale in record form in Vancouver music shops. She has completed five other songs since, all now in the process of being recorded.

Proceeds of sales from the songs will go to the Children's Hospital fund.

"It is out here in Children's Hospital among these tiny folk that I have found my place in this world," she said, "and perhaps my songs will go even further and provide financial help for these brave kiddies."

A person will not get anywhere by hitching his wagon to a star if he doesn't also put his shoulder to the wheel.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

L'Infirmière et la Lutte Anti-tuberculeuse

GEORGINE BADEAUX

L'attention de nos gouvernements semble fixée, plus que jamais, sur la santé. En effet n'est-elle pas une des plus grandes richesses d'une nation?

L'Association des Infirmières de la Province de Québec, heureuse de coopérer à toutes mesures visant à conserver la santé, se propose de recommander à toutes les écoles d'infirmières d'inclure dans le cours de base une affiliation en tuberculose. Mlle Badeaux expose dans l'article suivant les besoins de notre province et la contribution que pourront apporter toutes les infirmières, quel que soit leur champ d'action, si elles reçoivent durant leur cours une initiation scientifique et pratique en tuberculose.—S. GIROUX

LA LUTTE à la tuberculose dans la province de Québec a fait un pas de géants si on compare les statistiques d'aujourd'hui à celles d'il y a quelques vingt ans. On attribue cette baisse de morbidité et de mortalité aux campagnes éducatives et à la promotion de l'hygiène appliquée. Cependant, il ne peut être question de dormir sur des lauriers et croire que reculé, éloigné, l'ennemi est à notre merci, car il cause encore près de trois fois plus de décès dans notre province qu'il en cause en Ontario et en Saskatchewan. Le succès sur le passé doit nous donner de l'élan, nous assurer que vaincre est possible, et diminuer la confusion qui nous envahissait à la lecture des taux énormes de décès par tuberculose chez-nous.

Parce que la tuberculose est une maladie sociale, "le type même de la maladie sociale," a écrit le Dr Etienne Bernard, la législation sociale a secondé les médecins d'une manière drastique. Des fortes sommes ont été dépensées pour la prévention de la tuberculose, la construction et l'agrandissement d'hôpitaux et de sanatoria, pour supporter les frais d'hospitalisation de tuberculeux indigents, pour la formation de spécialistes dans le traitement de cette maladie. C'est un essor formidable qu'il faut continuer et l'apport d'infirmières qualifiées est instamment demandé.

L'infirmière a une mission *d'éducatrice.* Elle ne peut être qu'une main qui panse; elle doit être aussi une intelligence qui prévoit, qui cherche à maintenir intègre la santé publique. Au Congrès International du Nursing à Atlantic City, un orateur s'est écrié: "Pensez moins aux mots déprimants 'maladie et traitement'; pensez plutôt à la santé et à faire vivre un programme de santé aux gens."

Quand la profession du nursing a été conçue dans l'esprit et le coeur de St-Vincent de Paul, quand elle a été organisée scientifiquement par Florence Nightingale il n'y a pas eu dans l'esprit de ces inovateurs une sélection de malades à secourir; tous les malades ont été acceptés sans distinction. L'école professionnelle doit donc former des sujets secourables à tous, et plus spécialement nous, de la province de Québec, tristement affectés par la

Mlle Badeaux, licencière en sciences sociales, économiques et politiques, est infirmière technicienne au Comité Consultatif de la Tuberculose au Ministère de la Santé.

tuberculose, devons-nous subir un entraînement spécial à ce sujet?

La contribution de l'infirmière en tuberculose doit se faire:

1. Dans *la prévention*, pour laquelle il lui faut la connaissance des faits scientifiques essentiels, des statistiques, des procédés, et des organisations locaux de dépistage.

2. Au chapitre de *soins au malade* sont nécessaires: Un entraînement de protection personnelle parfaite en même temps qu'une étude sérieuse de soi-même sur son habileté à s'appliquer les principes de santé par des habitudes de vie saine. Il faut acquérir les connaissances du traitement moderne de la tuberculose, de la chirurgie pulmonaire et surtout ce deuxième but donnera la compréhension de la multitude des problèmes humains, sociaux, économiques du tuberculeux; problèmes qui l'encerclent et affectent son état de malade, augmentant par leur ténacité ou diminuant par leur solution ses espérances de guérison. L'énoncé d'un tel programme affirme de lui-même qu'il n'y a pas d'improvisation possible dans un tel champ d'action.

3. Plus tard quand l'ancien malade reprend une vie active dans la société, la sollicitude de l'infirmière est encore requise pour *sa réhabilitation*, pour éloigner de lui les récidives, maintenir fermement sa guérison, par la sagesse d'une existence soumise à la direction d'un médecin spécialisé.

Il est donné aux responsables d'une cause de saisir à certains moments toute l'acuité des problèmes qui se lèvent et qui peuvent emprisonner les moyens de réussite et métiger le succès. Ainsi, sans personnel compétent, sans un nombre suffisant d'infirmières initiées en tuberculose, comment la construction de nouveaux sanatoria, l'agrandissement de plusieurs autres, le dépistage massif de la population, la nouvelle efficacité qu'il faut faire donner aux institutions anti-tuberculeuses pourront-ils donner un plein rendement et même atteindre leur but? Questions angoissantes dont il faut attendre la solution de la générosité et de la formation des infirmières.

Toutes les spécialités du nursing sollicitent et méritent l'attention, mais la tuberculose décime les canadiens-français — il est logique que ce fait soit considéré. C'est évident que toutes les infirmières ne seront attachées à une organisation officielle de lutte anti-tuberculeuse, mais quel que soit le choix de carrière, quel que soit le milieu où elles évolueront, toutes, si elles ont une initiation scientifique et pratique en tuberculose, pourront être des volontaires et contribuer librement, de plein gré, à libérer la province de la servitude de la tuberculose.

Hemorrhagic Purpura

Hemorrhagic purpura is characterized by a low platelet count, prolonged bleeding time, and abnormal clot retraction. Examination of the sternal bone marrow after aspiration biopsy is of great value in establishing the diagnosis as well as in establishing the prognosis. The presence of normal regenerative changes in the erythrocytes, and particularly the presence of normal megakaryocytes, indicate that the cause of the decrease in the platelet count lies outside the bone marrow, and that in such instances splenectomy can be undertaken with the assurance that postoperatively there will be an adequate increase in the number of platelets. Conversely, if the bone marrow shows the absence of normal regenerative processes of erythrocytes or the presence of immature leukocytes, splenectomy would be contraindicated.

In the chronic and incipient forms of the disease of mild severity, splenectomy is not indicated until medical measures, such as removal of foci of infection, have proved inadequate. In cases of moderate severity splenectomy should be considered as a means of immediately improving the patients' health and preventing a dangerously acute exacerbation of the disease. In the acute forms of the disease, splenectomy is indicated when the diagnosis is definitely established. Splenectomy is the most certain means of preventing death from loss of blood or from bleeding into some vital structure.

The immediate results are as dramatic as can be found in surgery. Profuse bleeding, which is uncontrolled by all other measures, abruptly ceases with removal of the spleen and complete recovery follows permanently in most cases.

—*The Surgical Clinics of North America*

Notes from National Office

THE PRESIDENT and the general secretary of the Canadian Nurses' Association attended meetings of the board of directors of the International Council of Nurses held in London, England, September 16-21, 1948. The general secretary attended as representative of the Canadian Florence Nightingale Memorial Committee all meetings of the grand council, Florence Nightingale International Foundation. A synopsis of some of the committee reports presented at the meetings of the board of directors of the International Council of Nurses are given as follows:

Miss Gerda Hojer, president of the I.C.N., in her address to the board of directors, made a special plea for increased financial support for the work of the International Council of Nurses during these critical years when many countries are so dependent upon the professional help and support which the International Council of Nurses alone can give them. Reporting upon recent visits to various countries in Europe, the president outlined examples of the difficulties she encountered in Italy where the nursing service is carried by 8,000 graduate nurses and 60,000 auxiliary workers. The theory for the graduate nurses is on a minimum standard and quite the same theory as that given to the Red Cross auxiliary workers; the length of training courses in a school of nursing for a graduate nurse is, as a rule, not more than two years. The membership committee and the education committee of the International Council of Nurses must decide whether these two years are sufficient to measure up to what is required as a minimum for a graduate nurse in other countries. Active membership in the International Council of Nurses will help the nurses in Italy to succeed in their fight for better standards of nursing education and nursing service.

In Germany, the first problem is the same as that of Italy, namely, the training in nursing schools is for two years. There is also the question of re-establishing nursing organizations. To give the German nurses an opportunity to see a small, very simply organized association, the Swedish Nurses' Association has invited two German nurses who are working with the organization to study this problem in Sweden.

These visits, with their resultant helpfulness, are but a beginning of the many which should and can follow if we, the nurses of Canada, do our part to increase the present affiliation fees to the International Council of Nurses. (Our present affiliation fee to the International Council of Nurses is eight cents per capita.) We were delighted to learn that the American Nurses' Association had already doubled their affiliation fee to the International Council of Nurses and eight countries have unanimously agreed to do the same. Several other countries reported that steps were being taken to find ways and means to increase their affiliation fees.

Miss Daisy Bridges, executive secretary, reported steady increase in the work of the International Council of Nurses. She stated that it is very evident that the I.C.N. is recognized as the fact-finding, co-ordinating body in nursing envisaged in the report of the I.C.N.'s study committee. This recognition comes not only from nurses but also from leading persons in other professions. Much work is waiting to be done, such as collecting material and sorting out information on nursing conditions in all member countries, as well as in those seeking membership. The collection of nursing laws should be continued; at present, there are available in printed form nursing laws of only seven countries. The *International Nursing Bulletin* must be developed. The secretary also reported having spent a few days in Vienna during which she visited seven hospitals, talked with nurses, hospital directors, ministry officials, and representatives of World Health Organization and United Nations. As a result she was

able to make recommendations to the nurses themselves which, if implemented, will help in raising the status of the profession and in strengthening its relationship with other professional groups.

The education committee under the chairmanship of Miss Ruth Sleeper (U.S.) reported seeking opinions on the following from the education committees of the member countries: (1) What constitutes minimum standards of professional nursing education in the basic program? (2) What is the appropriate level at which such standards should be established today, in order to: (a) safeguard and further the development of professional nursing; (b) help member countries where professional nursing is not now well established; (c) set appropriate standards for membership eligibility in the International Council of Nurses? (3) What items should be included in the standards? (4) How detailed should these standards be? When these materials have been received from the members of the education committee an analysis will be made. The result will then be returned to the education committee membership for comment. After further revision, if such is necessary, the material will be sent to the education committees of the member countries for comment. Unless extensive revisions are then necessary the materials will be forwarded to the I.C.N. Executive Committee for consideration.

The nursing service committee, under the chairmanship of Miss Daisy Bridges, gave an excellent résumé of the work of this committee, which is responsible for: (a) Studying needs and resources as these relate to professional nursing service and of auxiliary workers in the care of the sick; (b) formulating acceptable standards of service; (c) clarifying various types of positions for professional nurses and auxiliary workers, these to be based on minimum qualifications which have been established for each position; (d) recommending other criteria relating to nursing service and methods for the expansion of nursing service.

Realizing the wide margin of our commitments, the limited time at our disposal before a provisional report must be presented to the board, and the probable lack of opportunities for members of the committee to meet before June, 1949, the committee decided to concentrate its attention within a limited area and to try to assemble facts relating to needs and resources. Realizing, moreover, that needs and resources in nursing relate primarily to needs of the community *for* nursing, and to numbers of nurses available to give adequate nursing care, the committee set itself as a first task to try and summarize from information submitted the reasons for and, if possible, some approach to the solution of, the problem of the grave shortage of nurses. In making this decision they were guided by the fact, based on discussions which took place at the meetings in the U.S.A. last year, that the problem of nurse shortage is almost world-wide, and that no country seems as yet to have formulated any practical solution.

A questionnaire was prepared and circulated, first, to all members of the committee and, later, in revised form, based on suggestions made by committee members, to the presidents of the twenty-eight national associations forming the I.C.N. Twenty-one replies have been received and this report was based on the material recorded in these replies. No attempt has been made as yet to produce exact statistical returns or figures. Much more accurate data is required from all countries in order to prepare such a return. Certain facts of interest and importance, however, have emerged from the replies, and an attempt has been made to summarize these and even to formulate tentative recommendations.

With few exceptions, the shortage appears to be most acute in curative rather than in preventive work, and particularly in institutions for the mentally sick, the chronic sick, and in sanatoria. An interesting piece of research is urgently needed to discover whether this shortage is due primarily to the type of work, or to conditions under which nurses are required to work. If the first is true, that the young person of today is averse to caring for the various types of sickness common to all communities, then the situation is indeed serious and our whole social structure is threatened; for it is frequently said that a country cannot survive unless it is prepared to care for the weakest members of its community. If, however, the shortage in these fields is due to conditions of employment, then instant steps must be taken to remedy the defects, and peoples and even governments made conscious of these defects.

From two countries — and these are countries where the shortage of nurses is most acute and where the need for more nurses runs into many thousands — it is

stated that there is reluctance on the part of educated and cultured members of the community to take up nursing, and that medicine, engineering, law, or teaching are more likely to be the professional fields chosen by educated women. It is interesting to know, in connection with one of these reports, that the introduction of the University or Collegiate system of training has strengthened interest in nursing among the more educated classes, which in its turn has led to improvements in the standard of nursing service.

That the need is urgent for improvement in working conditions in some countries is borne out by the following two reports: (1) "There is no shortage of graduate nurses where conditions of employment are good." (2) "There is no shortage of nurses where there is good organization and where regulations concerning protection of health, provision for old age, reasonable working hours, holidays, salaries, etc., as advocated by the national nurses' association, are respected." The following statement is made without comment but is worth consideration: "There is no shortage of applicants — in fact there are more applicants than positions to be filled — but the number of positions is conditioned by a government budget which limits the numbers of nurses permitted to be employed in each field."

Two reasons for a shortage of nurses occur with greatest frequency in replies to the questionnaire. These are: (1) The fact of the decrease in births following the first World War, and (2) the inadequacy of salaries still being paid to nurses. Thus, many young women who are completely dependent on earned income are deployed into other professions where greater amenities are offered. Further reasons for the shortage are listed as follows: (a) Limiting of working hours; (b) improvements in nursing care; (c) inadequacy of accommodation and training facilities; (d) increased demands in newer fields of nursing work, particularly in the preventive services and in industry; (e) increased demands for post-graduate study and experience, both at home and abroad.

It must be noted here that more than one country records the fact that many nurses have died in prisons and concentration camps or have not returned from foreign countries. Others have suffered in health through lack of food and worry, or are exhausted by the exceptionally hard work of the war years, while many are still suffering from the aftermath of war and from general post-war restlessness.

In speaking of shortage, only two countries report a wastage of student nurses during the training period. This wastage constitutes such a serious factor in those two countries that other countries, conscious of a shortage, might with profit examine their wastage rate and its causes.

Finally, a serious fact that is brought out in these reports reveals that more than eighty years after the birth of nursing as a profession and the founding of the first training school, student nurses in many countries are still exploited and are supplying cheap labor for the services of the hospitals. This situation is not only detrimental to good educational opportunities but is also a deterrent to many who would otherwise remain in the profession.

In view of the fact that because of the lower birth-rate, which must lead to a decrease rather than an increase of potential nurses during the next fifteen to twenty years, there is an urgent need for efforts to be made in the following directions: (1) A study of the best deployment of available resources in nursing, particularly between preventive and curative work. (2) A rationalization of the nurse's work, with an assessment of what actual duties are the province of the professional nurse and what properly belongs to the auxiliary group. Confusion on this point is evident in that some countries are working to bring in an auxiliary or practical nurse group; others already have her registration controlled by State Law; still others are working to do away with such a group. Moreover, it is impossible to gauge the numbers of auxiliary or practical nurses already in employment in countries where as yet no law exists to control them. (3) A constant drive for a raised social status for nurses, through improved material conditions, to include salary, living-out allowances, and other forms of social security. Concurrently with this, there should be better publicity in schools and the press, stressing that nursing is not only an honorable profession but an essential national service.

On all these and other urgent matters the nursing service committee will concentrate its attention during the next eight months, so that some conclusions of practical usefulness may be arrived at before the board next meets.

In conclusion, Miss Bridges made the following recommendations: (1) That in view

of the importance of, and the need for material to be made available from the fields of mental health and tuberculosis, representatives of psychiatric and tuberculosis nursing should be added to the personnel of this committee. (2) That in view of the rapid growth and development in the field of industrial medicine, an industrial nurse representative should be added to those already representing public health nursing on this committee.

Notes du Secrétariat de l'A. I. C.

La présidente et la secrétaire générale de l'Association des Infirmières du Canada assistèrent à une réunion du bureau des directeurs de l'Association Internationale des Infirmières. Cette assemblée eut lieu à Londres, Angleterre, en septembre dernier. La secrétaire générale assista aussi, à titre de représentante du Comité Florence Nightingale, à toutes les réunions du grand conseil de la Fondation Florence Nightingale. Voici résumé des rapports présentés à ces assemblées:

Mlle Gerda Hojer, présidente du C.I.I., dans son adresse, fit un appel pour que la contribution financière du C.I.I. fut augmentée; durant les années difficiles que nous traversons tant de pays ne peuvent compter que sur l'aide et le support du C.I.I. D'après les rapports faits à la suite de visites dans les différents pays d'Europe, la présidente donna des exemples de difficultés que rencontrent certains pays. En Italie, le soin des malades est assuré par 8,000 infirmières diplômées et 60,000 aides. Les cours théoriques donnés aux infirmières sont à peu près l'équivalent des cours donnés aux aides par la Croix-Rouge. La durée du cours est environ deux ans. Le Comité de l'Education du C.I.I. doit juger si ces deux années de cours équivalent au minimum exigé pour les infirmières dans les autres pays. Les membres actifs du C.I.I. aideront les infirmières de l'Italie, qui luttent pour obtenir de meilleurs standards.

En Allemagne, le même problème existe, à savoir un cours de deux ans; en plus, il faut réorganiser les associations d'infirmières. Afin de donner aux infirmières d'Allemagne l'occasion de voir une organisation simple d'infirmières professionnelles, l'Association des Infirmières de Suède a invité deux infirmières allemandes, qui travaillent à ce projet de rétablissement, à venir étudier sur place l'organisation en Suède.

L'on apprit avec plaisir que les infirmières des Etats-Unis avaient doublé leur contribution au C.I.I. Les infirmières de huit autres pays ont décidé d'agir de même. La contribution des infirmières canadiennes au C.I.I. est de huit sous par membre, ce qui ne permet pas de faire de largesse en notre nom.

Les demandes de renseignements abondent au secrétariat du C.I.I.; l'on veut connaître les conditions de travail dans différents pays, les lois, etc. Parmi les projets que la C.I.I. se propose de réaliser est la publication de toutes les lois concernant les infirmières dans les différents pays; actuellement l'on n'a publié que les lois de sept pays.

Le *Bulletin du C.I.I.* doit être développé.

La secrétaire du C.I.I. rapporta aussi qu'elle avait visité plusieurs hôpitaux à Vienne, ce qui a permis de causer avec plusieurs infirmières, de rencontrer des médecins, des directeurs d'hôpitaux, des représentants de l'organisation Mondiale de Santé des Nations Unies. Comme résultat, il lui fut possible de faire des recommandations, lesquelles si elles sont exécutées élèveront le niveau du nursing, du fait le niveau professionnel de ces infirmières, et leur donnera plus de considération vis-à-vis les autres groupes professionnels.

Le Comité de l'Education, sous la direction de sa convocatrice, Mlle Ruth Sleeper (E.U.), rapporta qu'un questionnaire était à l'étude, lequel porte sur les points suivants:

(1) Afin de donner le minimum d'éducation nécessaire à une infirmière professionnelle, que doit comprendre le programme fondamental? (2) A quel juste niveau devons-nous amener les standards du nursing, afin de (a) sauvegarder la profession et permettre son développement; (b) d'aider les pays où la profession d'infirmière n'est pas bien organisée; (c) d'établir des normes déterminant l'éligibilité des membres du C.I.I.? (3) Quels doivent être les standards de la profession? (4) Jusqu'à quel point doit-on détailler ces standards?

Lorsque les membres du Comité de l'Education auront répondu à ce questionnaire,

une analyse de leurs réponses sera faite, puis le résultat de l'étude sera envoyé au Conseil Exécutif du C.I.I.

Les causes du manque d'infirmières: Mlle Daisy Bridges fit un excellent résumé du travail accompli par son comité concernant l'offre et la demande ou, en d'autres termes, les besoins du public et les ressources que peuvent offrir les professions d'infirmières et les groupes d'auxiliaires. L'on a classifié différentes positions — celles qui devaient être occupées par des infirmières professionnelles et d'autres par des aides. L'on a déterminé les qualifications nécessaires pour chacune.

Le comité a décidé d'entreprendre en premier lieu l'étude des causes de la pénurie d'infirmières. Ce problème est international et aucun pays à date ne semble avoir trouvé une solution à ce problème. Cette étude n'est pas terminée, mais déjà elle semble indiquer que le manque d'infirmières est plus aigu dans les institutions d'aliénés, de malades chroniques, et dans les sanatoria.

Il faut étudier si la cause de ce manque d'infirmières dans ces institutions est due au genre de travail ou aux conditions de travail. S'il était vrai que les jeunes filles d'aujourd'hui ont de la répugnance à soigner certaines maladies que l'on rencontre dans toute société, ce serait grave et les bases de notre société du fait seraient menacées. Il est souvent dit qu'un pays ne peut survivre à moins qu'il ne soit prêt à prendre soin des plus faibles et des plus déshérités. Si tout de même cette pénurie est due aux conditions de travail, alors il faut appliquer le remède qui corrigera le mal; la population et le gouvernement devraient être mis au courant du mal à corriger.

Deux pays rapportent que les femmes instruites ne s'intéressent pas à la profession d'infirmière, mais qu'elles se dirigent vers d'autres carrières, tel que la médecine, le droit, le génie, l'enseignement, bien que ces pays manquent d'infirmières. Il est intéressant de noter que les cours d'infirmières organisé par les universités et les collèges semblent attirer les jeunes filles ayant une instruction supérieure et leur adhésion a aidé à améliorer le nursing.

D'autres pays rapportent: (a) Que l'on ne manque pas d'infirmières dans les institutions où les conditions de travail sont bonnes; (b) qu'il ne manque pas d'infirmières là où l'organisation est bonne, là où des mesures de protection sont prises en cas de maladie, caisse de retraite, heures raisonnables de travail, là où l'on suit les recommandations faites par l'association des infirmières. Dans certains pays, il ne manque pas de candidates pour les positions offertes, même l'offre dépasse la demande, mais les positions sont limitées au budget alloué par le gouvernement et du fait les positions sont limitées.

Deux autres faits mentionnés fréquemment comme cause du manque d'infirmières sont: (a) La diminution des naissances après la première guerre; (b) les salaires qui ont été payés aux infirmières et qui le sont encore à certains endroits. Il s'en suit que certaines jeunes filles, n'ayant aucune autre ressource que leur travail, se dirigent vers des carrières où elles peuvent immédiatement recevoir un salaire plus élevé.

Parmi les autres raisons données comme cause du manque d'infirmières sont: (a) Heures de travail moins longues; (b) amélioration des soins donnés aux malades; (c) logement et enseignement laissant à désirer; (d) la grande demande d'infirmières qu'exige la médecine préventive, les organisations de santé, l'industrie, etc.; (e) une plus grande demande d'infirmières qualifiées soit par des cours post-scolaires ou des expériences spéciales avant d'occuper certaines positions.

Plus d'un pays font remarquer que bien des infirmières sont mortes, en prison, ou dans des camps de concentration, ou ont été déportées et ne sont pas encore revenues. D'autres ont vu leur santé s'affaiblir soit à cause du manque de nourriture, de l'inquiétude, d'un travail trop ardu durant la guerre. En parlant de la pénurie d'infirmières, deux pays mentionnent la perte d'étudiantes durant le cours — il y a un gaspillage dit-on.

Enfin, il est grave de constater que de nos jours, après plus de quatre-vingt années d'organisation professionnelle et de la fondation d'une école d'infirmières, que bien des élèves dans plusieurs pays sont exploitées et l'hôpital fait faire à bon compte son travail par les élèves. Cet état de chose a pour résultat non seulement que l'élève ne reçoit pas une bonne formation, mais éloigne bien des jeunes filles qui dans d'autres conditions seraient heureuses de devenir infirmières.

En tenant compte du taux de natalité moins élevé qu'autrefois, ce qui veut dire probablement que le potentiel des candidates sera moindre dans les quinze ou vingt années à venir, il sera donc urgent de déterminer: (1) Comment employer les ressources qu'offre la profession, devons-nous considérer davan-

tage l'aspect curatif ou préventif; (2) organiser le travail de l'infirmière avec bon sens, lui faire exécuter les travaux qui demandent une infirmière professionnelle et laisser les autres aux aides; (3) travail constant pour élever le statut social de l'infirmière par l'amélioration des conditions matérielles d'emploie, tel que: salaire, indemnité, permettant de loger en dehors de l'institution, et diverses assurances sociales.

En plus, une plus grande publicité dans les écoles et dans les journaux devrait être faite sur l'honorabilité de cette profession si essentielle au bien-être du pays.

Supplemental Itinerary —I.C.N. 1949

TOUR N-3

Members of Tours N-1, N-1A or N-1B (see Nov. 1948 *Journal*) will have the opportunity of leaving the main party on its departure from Brussels, June 23, spending that night in Brussels and continuing over the following itinerary into Switzerland, Italy, the Riviera and Paris, etc.

June 23 **Brussels.** Half-day city sightseeing.
June 24 Leave by train for Basle.
June 25 Continue by train to Lucerne.
June 26 **Lucerne.** Rigi excursion.
June 27 Train to Milan.
June 28 Motor-coach to Venice.
June 29 **Venice.** Half-day sightseeing.
June 30 Motor-coach to Florence.
July 1 **Florence.** Half-day sightseeing.
July 2 Motor-coach to Rome.
July 3 **Rome.** Half-day sightseeing.
July 4 Motor-coach to Sorrento.
July 5-6 **Sorrento.** Excursion to Naples, etc. Excursion to Capri.
July 7 Motor-coach to Rome.
July 8 **Rome.** Half-day city sightseeing.
July 9 Motor-coach to Pisa.
July 10 Motor-coach to Genoa.
July 11 Motor-coach to Nice.
July 12 **Nice.** Grasse excursion.
July 13 Leave Nice by night train (with sleeping berth).
July 14 Arrive Paris.
July 15-17 **Paris.** One day city sightseeing. One day excursion to Versailles and Malmaison.
July 18 Leave Paris by night ferry (with sleeping berth).
July 19 Arrive London. Continue by train to Liverpool and sail on Canadian Pacific Steamship.
July 26 Due to arrive Montreal.

Nursing Sisters' Association

Toronto Unit: A large number of nursing sisters attended the twenty-third annual meeting held in January, with the president, Ethel Greenwood, in the chair. The Sunnybrook Hospital was the scene of the annual bridge in April, a success both financially and socially. A well-attended tea was held in June at Christie St. Hospital. The annual Armistice party took the form of an informal buffet supper, followed by bridge.

Since the annual meeting, four overseas boxes have been sent to British nurses. Two of these nurses were prisoners-of-war in Hong Kong, while the other two were referred to the N.S.A. through I.C.N.

Many members have taken advantage of the Blue Cross benefits which may be arranged through the convener — Miss E. Read, 384 Brunswick Ave.

Dangers of Rubella

Recent observations seem to indicate that rubella during early pregnancy may lead to multiple serious congenital defects in the offspring. This was first noted in 1941 following a severe Australian epidemic of German measles.

Among 78 cases of congenital cataract there was a definite history in 68 cases of German measles in the pregnant mother. Cardiac lesions were present in at least 44 of the 78 infants.

Further studies have shown that when a woman contracts rubella within the first two months of pregnancy it would appear that the chances of her giving birth to a congenitally defective child are in the region of 100 per cent, and if she contracts rubella in the third month they are about 50 per cent.

— *Selected*

STUDENT NURSES PAGE

Tuberculosis Affiliation in Saskatchewan

AILEEN HUTCHINGS

As I WAS fortunate enough to have been one of twelve students who went as affiliates to Fort San, Sask., I want to present the value of this training from a different viewpoint — that is, the reaction of the student to this form of affiliation. I see no better way of giving you these reactions than by opening up the pages of my diary.

The first view of Fort Qu'Appelle stirred me with mixed emotion; the typical small-town station and the usual crowd of curious townfolk welcomed me. My attention was attracted, on second glance, by an antique form of vehicle apparently meant as our means of transportation, as our luggage was being quickly packed into the relic known as the "San Bus." It was toward that same bus that we cast grateful looks as we boarded our homeward train eight weeks later. Decrepit though it was, it carried us without complaining, and without charge, back and forth from the train to the San.

FORT SAN

My first picture of Fort San is still very vivid to me. The buildings are placed in a semi-circle, the main section standing out domineeringly and the pavilions being up alongside. I possess an eager desire to see into every last corner of every structure, so I was deeply interested by the possibilities presented here. Added to this scenic display were the hills, completely enclosing the settlement, and the lake before them, a sheet of whiteness in the November sunshine. I pictured in my mind the beauty that must be there in summer. It's no wonder that Henderson chose the Qu'Appelle Valley as the setting for some of his famous paintings.

Our first day was filled with a series of chest x-rays, blood counts, urinalysis, physical examinations, and a general orientation into the course we were commencing. My first impression, and a lasting one, was the feeling of kindliness towards us. We were welcomed in so many ways that at the end of our first day our spirits were high and our hearts full of anticipation.

IN THE OPERATING-ROOM

The next morning, after breakfast, I meekly opened the forbidding door of the operating-room and entered into a set-up which, though miniature compared to our own, was immaculate in tidiness. Everything, I learned, was in accordance with my first appraisal of the three compact rooms. My duties were routine scouring and observing for the first few days, spending part time on the wards. I was quite thrilled, however, to scrub for a phrenectomy — a "phren" in San talk. The doctors were most instructive in their explanations and demonstrations, and readily illustrated the immediate paralysis of the diaphragm as the phrenic nerve was crushed.

By the end of the week I was assigned the responsibility of handling the pneumothorax apparatus. The meth-

Miss Hutchings was a student in the school of nursing of the Saskatoon City Hospital when she wrote this story of her experiences.

od of giving air is efficient and simple. Twenty to twenty-five patients receive air on two days of the week. There were three "pneumo" rooms with similar equipment as the one in which I worked. What amazed me greatly was the intelligent attitude of the patient toward pneumothorax treatment. "Getting a fill of air" was regarded as a social call with the doctors and the other patients. As the stretchers lined up in the corridors, opportunity was provided of meeting folk from different wings and floors.

The Children's Ward

My period on the children's ward was unforgettable. The children were all so normal in appearance and attitude that it seemed impossible that their small bodies harbored tuberculosis. I was particularly impressed with the way in which their lives corresponded so nearly to the normal child's. They had their school hours, their play hour, church and Sunday school, bath-time and story-time. Although many of them had been on strict bed rest for three or four years, they retained their irresistible chain of childish imaginations. To illustrate my point — One afternoon during rest hour, I was called to the boy's ward by a quiet "Nurse, come quickly." Fearing the worst, I rushed immediately — and was greated on opening the closed door by a box of water emptying on me from above. The master minds of eight-year-olds had adjusted the box and string so that when the door was opened the box turned. So I found myself drenched and from that instant was prepared for treachery. My own mind had to stretch a good deal, too, to keep up with all their cries for stories about "Supermouse and Bugs Bunny." Often it was difficult to restrain the children's exercise — they failed to understand why they needed rest when they felt so well. Restraining jackets were often necessary and, of course, the body cast inhibited the movement of many of them. Most of the children took heliotherapy treatments. They were exposed for varying lengths of time according to their age and strength.

A wonderful example of the way in which the children were prepared for the days when they would be cured, by endeavoring to maintain a life as normal as possible while they are undergoing treatment, was their Christmas concert. They all took part interestedly and were allowed to express themselves freely in their zeal over the coming of Santa Claus and the singing of carols. Even the small child is taught the importance of hygienic care. The two-year-old expectorates his sputum rather than swallowing it. They know, too, what "rest hour" means and that it is rigidly enforced.

Serving Meals

I must admit that I lacked faith in diet therapy until I saw proof of its efficiency at Fort San. A varied, balanced diet, high in caloric value and appetizingly served, appeared to play a major part in the patient's recovery. Poor appetites were catered to; likes and dislikes were considered and in this way the meal was an important item in their day. I learned in my week in the diet kitchen to calculate and prepare diabetic meals. There were only three trays so I had considerable time to contemplate caloric value and delectability. I was quite impressed by the system followed in serving meals. The serving was done in the main kitchen in each wing of the pavilion and the trays were placed on lifts and carried to their respective floors. It is all done very systematically and consequently very quickly. There were two dietitians who supervised the serving of trays and who did such a marvellous job of maintaining a varied menu.

Orthopedics

I spent two weeks on an orthopedic ward and in that time I feel that I really learned what constitutes adequate care of a patient in a cast. Lying thus in their shell is their treatment and if the cast is uncomfortable, that is, if it irritates any part, the cast is changed. With

young children, especially, it is necessary to change them every six to eight months as they grow out of them. One child, I remember, who complained of discomfort was found to have pushed a knitting needle under the stockinette and consequently she had developed a pressure sore. Pressure areas, however, are very seldom, in fact almost never found. Considering the length of time many patients are confined to bed rest in this way, this fact is rather astounding.

During my last week, I worked in the San infirmary. This wing consists mostly of far advanced and terminal cases and their nursing care was what I liked most. In thinking of the routine procedure of the San, I must comment on the technique carried out for protection of those working with the tuberculous patients. Gowns are worn when the nurse is near the bed; mouth-wash cups and drinking glasses are sterilized daily, likewise wash-basins and bed-pans; sputum cups and emesis basins are collected in a container of sawdust; paper handkerchiefs are collected in bags and disposed of daily; all wastes are wrapped in several layers of newspapers and burned.

Classes

Our class hours were frequent during the first two weeks of our course and gradually diminished as we reached the termination with a final examination. We had very interesting and interested lecturers. We were also privileged to sit in on the afternoon conferences every week. The medical men discussed patients on treatment all of which proved very interesting, especially if we happened to be nursing the patient under discussion. We were required to prepare a case study which was presented as an oral report at a thirty-minute conference with the instructor. Of great interest to us were our practical laboratory classes. We witnessed a guinea pig being inoculated and autopsies of others and gained valuable knowledge from seeing evidence of disease in the animal after ten weeks, following injection of positive sputum or of drainage from a lesion.

Social Life

Our working hours were short enough to allow us to enjoy the social life the San afforded. Curling and skating were predominantly first on our list. Dances and shows were frequent and, of course, we also made our own entertainment in the residence. If I gained nothing more from my affiliation at Fort San, I gathered a broadening outlook towards other schools of nursing from discussions and hours of shop-talk.

Our eight weeks terminated too quickly. Soon the trunks were piled into the old faithful San bus and we made our last journey into town. Our farewells were made rather sorrowfully as we had become attached to the little community which was Fort San.

In closing, I cannot adequately express my appreciation for the affiliate course. I feel that I gained a knowledge by being in direct contact with the program in the eradication of tuberculosis, and have learned to understand the work being done by the League. I feel prepared to be of greater assistance as a nurse and as a citizen to participate in the fight to eradicate the disease.

Insecticides and Health

An acute problem is occasioned by the wide use of insecticides, fumigants, and other chemicals in agriculture and related industries. Airplanes now dust crops with chemicals many times more potent than DDT. A number of cases of illness have been reported. Even the innocent sprouting of potatoes is not immune from the demon of mass production. Now potatoes can be made to sprout faster by treating with ethylenechlorhydrin. Price for this speed-up is at least one man killed and six made seriously ill by inhaling the deadly vapors.

— *California's Health*

Nursing Profiles

Monica Mary Frith is now the director of nursing with the British Columbia Department of Health and Welfare. Born in Prince Albert, Sask., she graduated from the Vancouver General Hospital in 1939. Miss Frith holds her B.A. and B.A.Sc. from the University of British Columbia, her M.P.H. from the University of Michigan. She received the latter degree while on a scholarship from The Commonwealth Fund of New York.

Miss Frith has considerable experience in rural public health nursing work as the background for her present duties. She has worked in both single and multiple nurse districts, as generalized consultant under the provincial health department, and latterly as assistant director. She is very interested in expanding community health facilities. For relaxation, she turns to golf.

Margaret Augusta Evans has been named acting director of public health nursing in the provincial service in Alberta during the absence of **Jean Clark,** whose appointment to the province's health survey committee has been announced. **Blanche Emerson** has been named as assistant director for this period.

Dorothy Gwendolyn Thorp, R.R.C., after twenty-one exciting years with the Queen Alexandra Imperial Military Nursing Service, has retired from active military service and was recently named supervisor of central surgical supplies at the Kingson General Hospital. Born in London, Eng., Miss Thorp graduated from Royal Northern Hospital. She received her first commission in 1927, the starting-point for her colorful career.

Her first foreign posting took her to India for over five years. Such magical foreign names as Mhow, Jubbulpore, and Quetta began her long list. During the Abyssinian emergency, she was transferred to Alexandria as divisional sister. Three months later she went to a military hospital in Jerusalem. In 1937, she was sent to Cairo to study administration. Promoted to matron, Miss Thorp was recalled to England in 1939 to assist with the mobilization of the hundreds of nurses called up for military service. A year later she was back on the desert at Suez. With tension mounting in North Africa, Miss Thorp gave up her rank as principal matron in order to go to Tobruk and care for the wounded during the darkest days of 1942. As a part of the famous Eighth Army, Miss Thorp had charge of four ambulances, each carrying two nursing sisters and medical supplies. Battle areas at Barci, Benghasi, Marble Arch, bypassing Tripoli to Medinin, Mareth, Gabes, Sfax became sites for C.C.S. hospitals.

Twice mentioned in dispatches and recipient of the Royal Red Cross, Miss Thorp returned to England in 1945 only to be sent

McAllister, Victoria

MONICA M. FRITH

Fawdry, Calgary

AUGUSTA EVANS

abroad again the next year to Lagos, West Africa. On her retirement in 1948, following her final posting as principal matron at a military hospital in Chester, Miss Thorp came to Canada. We hope she will like us well enough to remain a long time.

Destined for leper work at Spanish Town, British West Indies, is **Sister Mary Ambrose.** An Olympic swimming and diving star, a former Y.W.C.A. physical instructress at Calgary, and Canadian sports champion, it was her participation in these events which led her to this life work now being undertaken.

Travelling to Australia for the 1938 British Olympic games, Sister Mary Ambrose — then Marie Sharkey — first met the Marist Missionaries, two of whom were on the ship en route to Samoa and the Fiji Islands. Intensely interested in the story of their noble work among the lepers, Miss Sharkey decided to join the Order and upon her return visited the Mother House at Framingham, Mass.

She entered the religious order in 1940 and since then has completed her nursing course at St. John's Hospital, Lowell, Mass., graduating in 1947. In May of this year she passed her registration examinations in Saint John. Her early school studies were taken at the Sacred Heart School in Calgary.

Sister Mary Ambrose has visited in Saint John many times and has a wide circle of friends and relatives who will wish her Godspeed and happiness in her field of endeavor.

Maude Helen Hall has retired from her position as chief superintendent of the Victorian Order of Nurses for Canada. During the war years, Miss Hall was acting chief superintendent, assuming the full title in 1947.

Born in Guelph, Miss Hall was educated in Ontario, graduated from Johns Hopkins Hospital, and received her public health training from the school of nursing at the University of Toronto. During World War I, she served in France as a nursing sister with Base Hospital No. 18, the Johns Hopkins Unit. After practising for two years as a private duty nurse, she joined the staff of the Massachusetts-Halifax Health Commission, and then for two years she gained experience as a member of the nursing staff in the city of Toronto Department of Health. Ever keen for new opportunities to develop her knowledge of nursing service, Miss Hall became a

MAUDE H. HALL

supervisor in the Instructive Visiting Nurse Society in Washington, D.C., and later director of the Visiting Nurse Association of Holyoke, Mass. In 1928, she joined the staff of the Public Health Clinic of Dalhousie University, and in 1929 was appointed assistant superintendent of the V.O.N. and brought to the Order the wealth of her rich experience. In recent years, the award of a Rockefeller Travelling Grant made it possible for Miss Hall to spend several weeks visiting nursing organizations in the United States.

After so many active, fruitful years and a job well done, it seems a happy circumstance that Miss Hall, retiring from the highest post in the V.O.N., should have leisure for the things she loves — art, music, her insatiable reading, and those long walks she endorses. She will be missed for her facile mind, her charm and her smile — sometimes even her quick flashes of temper — and above all for the enthusiasm and the leadership she gave, both in her role of acting superintendent and later as chief.

After giving twelve yearsas superintendent of nurses and in all twenty-three years of faithful and efficient nursing service to the Saskatoon Sanatorium, **Rhoda Smith** has retired.

Although Miss Smith was born and educated, including normal school, in eastern Canada, her training and entire nursing career have been spent in Saskatchewan. After a

short teaching career, she entered the Saskatoon City Hospital, graduating in 1916. Following graduation she remained on the staff of her alma mater for nine years, acting as night supervisor. In 1925, Miss Smith joined the nursing staff of the newly-opened Saskatoon Sanatorium.

She took an active part in her alumnae association, in the Saskatoon Chapter of S.R.N.A., and in the Quota Club.

Prior to her departure for eastern Canada Miss Smith was presented with many gifts from various organizations and her nursing staff.

Gertrude I. Anderson, who was one of the pioneers in the public health nursing field in Nova Scotia, has retired. A graduate of the Massachusetts Homoeopathic Hospital, Miss Anderson served in France during World War I with the Queen Alexandra Imperial Military Nursing Service. She began her public health nursing career in Yarmouth in 1923 and went to Annapolis Royal in 1932. Her work as a public health nurse has been most outstanding and she is beloved by every child in the schools of Annapolis County. At a special gathering Miss Anderson was presented with a suitcase.

In Memoriam

The most able and far-sighted statesman that the nursing profession has had since Florence Nightingale died on October 3, 1948. **Mary Adelaide Nutting,** who, though most of her life for nearly sixty years was spent in the United States, was proud of her Canadian heritage and who retained her Canadian citizenship to the end, has passed away.

In the autumn of 1889, a thoughtful young woman of dignity and charm, of intelligence beyond the average and with a personality which quickly impressed itself upon her classmates, entered the school for nurses of the Johns Hopkins Hospital. Adelaide Nutting was never especially robust, but she managed to hold her own physically with the strongest during the long hours of work. Graduating in 1891, Miss Nutting remained for two years as head nurse in different wards, then was appointed assistant to Isabel Hampton, succeeding her as superintendent of nurses and principal of the school in 1894.

ADELAIDE NUTTING

Recognizing that schools of nursing were not meeting their obligations, she attacked the problem with thoroughness and courage. Early in 1896, she established simultaneously the three-year course of training, the eight-hour day for student nurses, and abolished the monthly money allowance to students. Then followed, year after year, a succession of advances and reforms. Tuition fees were made a requirement; scholarships were provided; lecturers were paid. During these busy days, Miss Nutting found time to collaborate with Miss Dock in the preparation of the History of Nursing.

Miss Nutting took a prominent part in all matters pertaining to nursing organizations. She was the leading spirit in securing passage of the first Act for the regulation of nursing in Maryland. She was twice president of the American Society of Superintendents and was also president of the American Federation of Nurses, the forerunner of the American Nurses' Association.

The deplorable state, educationally considered, in which even the best schools of nursing found themselves at the turn of the century, led Miss Nutting to urge the establishment of university courses where instructors might be trained. Teachers College, Columbia University, was the first

to undertake this task. In 1907, Miss Nutting was appointed the first director of this new department. It was fortunate for nursing that she chose this pioneer field and threw into it all her enthusiasm and her rare gifts of mind and spirit. With her students she was a very stimulating and helpful person who asked penetrating questions and who made them want to do things they had never dreamed of before. When she retired in 1925, after eighteen strenuous years, the work of the hundreds of students from many countries whom she had had a share in training bore testimony to her vision and acumen.

Nursing will continue to advance in professional attainment, but whatever the superstructure that may yet be built, its strength will greater become because of the sound foundation laid by Adelaide Nutting.

Margaret Clotilde Macdonald, R.R.C., who served Canada with pride and distinction as matron-in-chief with the C.A.M.C. in the first World War, died on September 7, 1948, in her seventy-sixth year. Born and educated in Nova Scotia, Miss Macdonald received her professional training at the New York City Hospital, graduating in 1898. Three years later she was selected as one of five Canadian nurses for the then small C.A.M.C., putting into use the knowledge and skill she had gained in military hospitals in the United States nursing soldiers wounded in the Spanish-American War. With this unit she went to South Africa. Miss Macdonald was the first woman to enter the beleaguered city of Kimberley after its relief.

Shortly after her return to Canada, construction of the Panama Canal was underway. Men were dying of yellow fever and malaria. In 1903, Miss Macdonald joined the United States forces engaged in combatting these pests. Here she gained vast experience in nursing tropical diseases and contracted malaria herself.

In 1906, Miss Macdonald rejoined the C.A.M.C. and served in Halifax, Kingston, and Quebec. Five years later she was sent to England to study the administration and mobilization of the Queen Alexandra Imperial Military Nursing Service, an experience that stood her in good stead when in 1914 she was appointed the first matron-in-chief of the nursing service with the Canadian Army. King George V presented her with the Royal Red Cross in 1916. She received the Florence

MARGARET MACDONALD

Nightingale Medal in 1918 and, upon her retirement from the C.A.M.C. in 1920, St. Francis Xavier University bestowed an honorary LL.D. upon her. In 1940, her portrait was painted in oils at the request of the Overseas Nursing Sisters' Association. It is hung in the Council Room at Defence Headquarters in Ottawa. While her health permitted, Major Macdonald always paraded with the nursing sisters on Remembrance Day.

Helen A. DesBrisay, who graduated from the Montreal General Hospital in 1897, died in Montreal on October 12, 1948, at the age of eighty-five years.

Josephine M. Dickie, a native of Campbellton, N.B., who graduated from the Toronto General Hospital and practised her profession in New York, died recently in Lachute, Que.

Elizabeth Fales-Jones, nursing sister in World War I, who was awarded the Royal Red Cross of Belgium and the Croix de Guerre, died on September 4, 1948, after a lengthy illness. Born in Quebec City, Mrs. Fales-Jones obtained her nurse's training in New York. She went to France in 1913 and soon after the outbreak of war joined the nursing service of the Belgian army. There she worked closely with Edith Cavell and was taken

prisoner. Upon her release, she served for a while with the British Imperial Army, transferring to the C.A.M.C. in 1917 and serving at No. 6 Canadian General Hospital on the Western Front. Following her discharge, Mrs. Fales-Jones joined the staff of the Juvenile Court of Montreal as first Protestant probation officer. She retired in 1944.

Rose Korchinski, a 1940 graduate of St. Paul's Hospital, Saskatoon, and at the time of her death a member of the Saskatchewan Division of Public Health Nursing, working in Yorkton district, was killed in an automobile accident on September 6, 1948. An active member of the Yorkton Chapter, S.R.N.A., Miss Korchinski had a great zest for living and will be sadly missed.

Magelena Riffel, a second-year student nurse at the Regina Grey Nuns' Hospital, died on September 3, 1948, at the age of twenty-one, following a brief illness.

Australian Nurses' War Memorial

MARGARET LAWRENCE

As a memorial to seventy-five Australian nurses who lost their lives in World War II, their fellow nurses have planned a War Nurses Memorial Centre that will be a landmark in the history of nursing in Australia.

The Centre has been planned on a generous and comprehensive scale. The chief feature will be a college at which nurses may undergo post-graduate training for higher administrative and executive positions without having to go overseas. Within recent years, some twenty-five Australian nurses have taken post-graduate courses at the Royal College of Nursing, London, under scholarships provided by the Florence Nightingale Memorial Committee. Teaching staff of the Centre will be chosen from these nurses.

The first post-graduate courses will be in administration and sister tutor work, with probably industrial nursing and a course for ward sisters to follow.

The Centre will enable all organizations connected with nursing to be housed under the one roof. Social and recreational facilities will be provided, with lounges, hall, dining-room, library, writing, and indoor sports rooms. There will be special facilities for disabled war nurses and nurses awaiting or recovering from hospitalization. The residential block will be of about forty rooms.

The sum needed for the purchase of a Melbourne city building considered ideal for the purpose is £100,000 ($320,000). The committee is confident that the required amount will be subscribed and the centre opened by the end of 1948.

Victorian nurses worked enthusiastically to raise funds for the Centre, making dona-

Australian Official Photos

Contestants in the Queen of Nurses competition

You know, you do more for your patient than you might think . . .

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Australian Official Photo

Sisters Bullwinkel and Jeffrey with the Chinese Malayan nurses

tions, holding fetes, and giving up their spare time to make collections in streets and public gatherings. Chief source of revenue was a Queen of Nurses competition, for which all the city hospitals and many provincial hospitals entered candidates.

Another function which helped the appeal was a carnival featuring radio and stage stars, which was attended by over forty thousand people. Among those who took part in a parade of nurses were Sister Vivian Bullwinkel, only survivor of twenty-two Australian nurses who were machine-gunned by Japanese troops on Banka Island, and Sister Betty Jeffrey, whose nursing kept her friend alive throughout three years in concentration camps in Palembang.

Two Chinese Malayan nurses who are studying children's nursing in Melbourne under the AIF scholarship for Malayan nurses also took part in the parade, which included the heads of the wartime nursing services, matrons of hospitals, and candidates for the "Queen of Nurses" competition representing sixteen city and sixteen country hospitals.

The idea of a memorial was first raised after the sinking of the Australian hospital ship *Centaur* by the Japanese in 1943, when eleven nurses, all save one on board, were drowned. A *Centaur* memorial fund was started to provide post-graduate nursing scholarships, but it was felt that this did not reach a sufficient number of nurses.

Then, as it became known how many nurses had lost their lives and how heroically they had died during and after the Malayan campaign — in bombed Singapore, on torpedoed hospital ships, at Banka beach, in Japanese concentration camps — the feeling grew that their only fitting memorial would be one that would benefit all nurses, give them the facilities to do better work for the sick, and thus raise the status of the profession. The present plan is the result.

Life in the Belgian Congo

Editor's Note: There are few corners of the earth where, at some time or another, Canadian nurses have not served. In those halcyon days when travel was a simple matter, many nurses, literally, worked their way around the world. Today, our former colleagues are still serving in many remote spots. The author of these letters, Allison (Jamieson) Henderson, is one of those who journeyed far from home. Her letters reveal the life and work of medical missionaries in the native villages of the Belgian Congo. We reprint excerpts from them, believing you, too, will enjoy the tale they tell of courage, of fun, of hard work, of homey happiness.

Mrs. Henderson graduated in 1935 from the Winnipeg General Hospital. After a year on the staff of the Winnipeg Municipal Hospitals, she worked in public health nursing and in the Cancer Research Institute. In 1938 she attended Teachers College, Columbia University. Late in 1939, she was married to Dr. A. G. Henderson, a graduate of the University of Manitoba, They were appointed to their work in 1940, and a year later sailed on board the Egyptian ship *Zam Zam*, which was sunk by a German raider. After many vicissitudes, including jail and internment camps, Mrs. Henderson was returned to Canada in 1942. Dr. Henderson escaped into

Switzerland in 1944 and eventually reached Winnipeg. In August, 1945, they sailed again for Africa. The letters cover the ensuing two-year period.

November, 1945: A wonderful reception was given by the natives who came in hundreds to wait along the river bank for the doctor and nurse to finally arrive. They sang as the boat approached, then carried their gifts of fruit, food, etc., to us. Our supplies, which had been sent on a different ship in 1941, had been kept in excellent condition and our new home was all ready for us. There were French doors leading to the open porch where a beautiful view of the river, flowers, fruit trees and cocoanut trees could be obtained.

Our hospital is in dire need of workers. I am helping with the lab. work (mostly T.B. and leprosy) and am trying to teach a boy to help. Every day Fred does major surgery — herniotomies, huge tumors, etc.— with the aid of only one assistant. The operating-room is a red brick building painted white inside and I have made large supplies of surgeon's gowns, laparotomy sheets and dressings. We have a good autoclave.

About ten days before Fred commenced any surgery, and while the hospital was being painted, a man came in, having journeyed three days, with a strangulated hernia. There were no sterile supplies so, amid wet paint and insects, we prepared for the operation. It was evening and, as there was no electricity, he operated by lamplight. Though it was thought that the man did not have a chance to live, we were very grateful that he recovered. It was Fred's first operation and I suppose about fifty natives were silently watching through the open windows.

Mrs. Henderson and Douglas

One hears the native drums in the village late into the night — just the sounds one expects to hear in Africa. The Lonkundo is a musical language. We have daily lessons but it will take me months to speak it fluently. My cook and wash-boy understand my French so we get along.

January 26, 1946: Of course the biggest event was our Douglas Norman. He is really a beautiful baby. We have started him on cod liver oil, orange juice, and sun baths.

Fred has had several emergencies. One man came in with compound fractures of the arm and leg, and flesh wounds. His canoe had been upset by a hippopotamus and then the animal had gored him.

One of our greatest needs is for a tuberculosis sanatorium as there are so many advanced cases here and, living as they do in crowded huts, it is rapidly spreading. There is a lot of leprosy, too, and we need a leper colony in this area. There is just too much essential work and too few medical workers. Venereal disease is a major problem and hundreds come for injections.

I wish you could see the adorable native children. They come to the door several times a day to see Douglas. For them he is the first white baby and it is priceless to watch them exclaim and see the animated expressions on their faces.

Two weeks ago the congregation of the church assembled in our yard for the naming of the baby. It is their custom for the elders of the church to give the baby a native name so they call him "Bokunga" and, in payment, we had to give them a sack of salt, which they divided among themselves.

April 8, 1946: Fred is very busy at the hospital and hundreds come to see him daily. He gives injections on Mondays and Fridays when about eight hundred come for treatment of venereal diseases, sleeping sickness, yaws, etc. On Tuesdays and Thursdays he does major surgery, with four or five opera-

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1948 INDEX

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tions daily, mostly herniotomies, fibroids, etc. Wednesdays and Saturdays he sees new patients and has pre-natal clinics. Besides these, he has hospital rounds, dressings, supervision of food, etc.

With so many sick people and their relatives coming in, there is an acute housing shortage so we are having twelve eight-roomed "apartment houses" built. Each room will house relatives. These are being made with mud walls and thatched roofs. It is fun to watch them cooking over little fires in the middle of the floor.

I started a baby clinic last week with fifty children attending. Next week I will include those from the village as well, so will likely have over a hundred. Half of them are naked or perhaps have only a string of beads around their tummies.

April 21, 1946: I wonder if Easter is as lovely in Canada as it is here. From my window I can see the many-colored flowers, the palms, and the river.

Though we are up at 6:00 a.m., the days never seem long enough. At 7, I have four babies brought for cod liver oil and to have their 24-hour formulas made. At the baby clinics I am trying to teach them cleanliness so I give them a bar of soap each week.

June 1, 1946: While out walking yesterday, we came across a native woman brightly painted in orange, doing a dance. In normal life she is really quite attractive.

Two weeks ago we had a leopard on our back porch at 4:00 a.m. There was a paw mark on the screen where he had leaped at our cat. There have also been elephants and hippos in the vicinity recently.

October 10, 1946: We have our tennis racquets but have no courts yet, however. When we have time, we play badminton and ping-pong.

As we had eleven guests recently we were thankful to have boys to help. Though we have to tell the boys several times a day about a job to be done, they keep wanting a raise in pay. On the whole, they do very well and I will never cease to wonder how they learn to cook so well for white folk when their food is so different.

Recently, a missionary was brought in for surgery and, as the weather was stormy, we could not take her to hospital so had to transform our living-room into an operating-room. Two native nurses assisted and I was waiting nurse. We had a few anxious moments when our patient had a weak spell, but after treatment for shock and intravenous and nasal suction she recovered.

I just never seem to have time to study the language and the natives must think I am awfully dumb. However, the house-boys and nurses understand me so I am not worrying.

February 12, 1947: In December, Douglas celebrated his first birthday with a garden party, during which he got his fist into the icing of his birthday cake and smeared it all over his face.

Fred injured his leg recently on his motorcycle and, despite precautions, infection set in. He was in bed ten days and with a patient, a baby, and a house and hospital to look after I didn't have too much time on my hands.

Then an emergency case came in and Fred had to be carried to the hospital and had to stand for two hours while he operated. Both patient and doctor survived. Really, there is never a dull moment here.

A few days ago Fred had just completed his regular morning surgery when a man was brought in with his head badly injured. He had fallen from a palm tree while cutting palm nuts for food to be used following an operation he had just made arrangements for. Just as this operation was completed, a man was brought in with a spear wound in his hip. That evening, a woman was brought in with her lower lip bitten through — she had been in a fight with the other wife in the "harem." So that was a Congo day for us.

July 2, 1947: We are having quite an epidemic of measles here.

We are giving atabrine to the baby as a precaution against malaria and are also immunizing him against the other diseases. He is definitely showing a preference for the Lonkundo language which he hears all the time. He is a regular little mischief and gives us no end of joy.

A native woman was brought into hospital only three or four minutes after having been bitten by a snake and, despite emergency measures and serum, she died. On reading up about snake bites, we find that a cobra can inject enough poison at one time to kill twenty people.

September 3, 1947: At last we have been able to obtain a supply of paludrin and are using it now to prevent malaria. Fred is booked up in his surgery until next April.

More than one hundred babies are brought to our clinic now. Oh, there is so much to do that it is impossible for us to more than scratch the surface.

Fred hopes to open rural dispensaries soon which may relieve the congestion here but to find time to do this is another thing. We can just do so much.

Douglas is a regular little imitator and, when Fred says Grace before meals, Douglas folds his hands and chants some little lingo all his own.

October 8, 1947: We have had an outbreak of smallpox and, though we have repeatedly tried to vaccinate everyone, we have not been able to obtain proper vaccine.

A new doctor, who at present is studying in Belgium, is coming out to the Congo. He will spend three months with us at Monieka.

December 14, 1947: We have been delighted

to receive your boxes of Christmas decorations and we are most appreciative of everything.

At present I am translating a book of health fables from English to Lonkundo and I am going to use one of these fables at a women's meeting next Thursday. Fred and I are both working hard on the language as we still have one examination to write before leaving for home on furlough. Part of the examination consists of doing twenty-five pages of translation work, which takes many hours. It is quite a task trying to study, and prepare enough work for a daily lesson.

Yesterday was Douglas' second birthday so we put up a swing in the porch for him. How he loves it! We also had a party for him and the missionaries' families all attended. We took several movies, including those of the guests arriving, of Douglas opening his gifts, of games played, of the guests seated at the table, and finally of Dougie climbing into bed.

December 25, 1947: At Christmas time we had a Christmas tree made of palms and decorated just as we do in Canada.

Early that morning the natives, who had been trained by the missionaries, proudly put on Bible plays, particularly of the Nativity. They love taking part in these plays.

January 25, 1948: We have had a very busy time the past two weeks.

A state man was here investigating a man who was supposedly either murdered or drowned. Apparently a canoe had upset and all but one man had managed to climb in again. When he attempted to do so, the others, fearing that he would upset the canoe again, whacked at his fingers and at the back of his neck until he finally let go and was drowned. Then they secretly buried him but relatives discovered what had happened and reported the crime to the state man.

Last Monday I had been at the hospital until 11:00 a.m. and Fred had just completed a language lesson when a very ill native baby was brought to our home. It had pneumonia and had to be given heart stimulants. At 11:30 a.m. its heart ceased to beat and we believed it to be dead. The young parents had run out of the house and were rolling in the grass and crying out. We made an air passage and commenced to give artificial respirations immediately and we continued to do so from 11:30 a.m. to 5:00 p.m. By then it had taken several gasps, then would again cease to breathe, when we would begin the artificial respirations again. By 5:00 p.m

its respirations became fairly regular and its pulse was of fair volume. The baby and parents remained at our home all night and we gave penicillin every three hours. By morning the baby had improved. After remaining with us a second night, the parents happily took their precious baby home the third day. I have been out to see him several times and one would hardly know the close call he had had.

The natives, of course, were amazed as many of them had watched us working over the baby. It is the biggest miracle I have ever witnessed. The parents are young, are students in the school, and they had taken such lovely care of their baby. We are so thankful that he survived.

Book Reviews

Diabetes & The Diabetic in the Community, by Mary E. Tangney, R.N. 259 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1947. Price $3.00.

Reviewed by Florence Archibald, Clinical Supervisor, Toronto General Hospital.

"More than 25 per cent of the population carries the diabetic trait." "Diabetes now ranks seventh as a cause of death."

These statements alone should prove that there is an increasing need for enlightenment of the public on the subject of diabetes. This book collects detailed information on the study of diabetes — etiology and prevention, complications, problems of adolescence and childhood, with many suggestions for helping the young diabetic to adjust to this disease and follow the prescribed treatment.

Considerable information is given on diet management which would be of great value to any nurse in helping the patient plan his diet. No doubt there will be differences of opinion with the writer's preference for the type of insulin syringe and method of sterilization of syringe and needle.

This book is written to assist the public health nurse in all phases of teaching the diabetic, but would also be of inestimable value to the institutional nurse.

Essentials of Nursing, by Helen Young, R.N. and Eleanor Lee, A.B., R.N. and

associates. 556 pages. Published by G. P. Putnam's Sons, New York. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1948. Illustrated. Price $4.00.

Reviewed by Frances McQuarrie, B.A.Sc., Supervisor of Instruction, University of Alberta School of Nursing.

In Young and Lee's "Essentials of Nursing" is found the application of basic sciences to actual nursing arts in a style and arrangement that is pleasing both to the eye and to the mind. The book is very readable, as compared to some rather highly enumerated texts of recent years, but is at the same time well marked for easy reference.

As the content is prepared for schools of nursing in the United States, a portion of the chapter on the Social Aspects of Patient Care cannot be used here in Canada. However, those parts dealing with the patient and his environment are well done and true to the set-up in almost any well-run, modern North American hospital.

The technical information is concise, scientific, and clear, the chapter on Surgical Dressings being particularly good. It lists many points in technique that have been handed down in the past mostly by word of mouth. Line drawings accompanying each section are clear and simple, illustrating, in many cases, a single principle or piece of equipment. This enables the reader to grasp the particular point in question very quickly.

The appendices are adequate although they would have been more useful with a list of prefixes, suffixes, and combining forms for a technical vocabulary. The physical characteristics of the book are not free of fault, for, although not unusually heavy, it is very bulky.

On the whole this book should be very useful, both as a prescribed text for student nurses or as a supplemental text on the library shelf.

Nutrition in Health and Disease, by Lenna F. Cooper, B.S., M.A., M.H.E., Edith M. Barber, B.S., M.S., and Helen S. Mitchell, A.B., Ph.D. 729 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 10th Ed. 1947. Illustrated. Price $4.00.

Reviewed by Kathlyn Bettington, Assistant Dietitian, Royal Victoria Hospital, Montreal.

The tenth edition is based on the same

principles as were outlined in previous editions. The authors state that the book presents "the newer ideas in both the principles of nutrition and the practice of dietetics, based upon the most recent experimentation and study as well as established knowledge of earlier research findings." It is a reliable textbook and affords an excellent source of reference material. The two-column pages and good glossary lend greater ease in reading.

The content of the book has been arranged in four parts. Each part contains graphic charts, illustrations, and summaries to aid the reader. This regrouping of old and new material is conducive to a sequence of subject material so related as to make studying more interesting.

The first part, Nutrition and Optimum Health, besides discussing the food constituents themselves goes one step further and gives timely information about the role of nutrition in present-day world-wide problems. Public health workers will find valuable material here.

Those interested in nutrition in hospitals will appreciate the information on special diets. As in previous editions "the use of the basic dietary pattern is recommended throughout to ensure that all diets will be adequate nutritionally, even when restricted because of specific disease."

Discussion of food groups appearing on a menu and reliable recipes for each will prove valuable to both professional and lay people.

The Tabular Material and Special Tests included in the fourth part offer simplification and usability of tables without sacrificing accuracy. The authors have included tables in accordance with information required in the new emphasis in diet therapy as highlighted in the second part.

℞ *Chuckles* P.R.N.

The Schick test is used to tell whether a person is acceptable to diphtheria.

The patient co-operated well with early ambulations.

A post-mortem should be treated with tact and consideration.

The best milk that can be obtained comes from a pasteurized cow.

Something you are born with is congenial.

Any doctor must be watched between handling babies.

Care of measles patients: Keep them in the dark, eliminate their bowels, and give them a soft diet.

Treponema pallidum is spread from mosquitoes to man and from man to mosquitoes. Therefore, screen all windows.

Dietary Requirements in Pregnancy and Lactation

Striking changes in normal physiologic processes during pregnancy and lactation impose heavy demands on the mother. Two of the broadly significant factors in nutritional deficiency in the maternal organism are the impairment of digestion and absorption, particularly in early pregnancy; and the elevation of nutritional requirements in late pregnancy and during lactation.

The nutritional allowances for pregnancy (fourth through ninth months), as recommended by the Food and Nutrition Board of the National Research Council, are given in the following table:

Nutritional Essentials	*Norm.*	*4-9 mo. Preg.*	*Lact.*
Calories	2100	2500	5000
Protein (gm)	60	85	100
Calcium (gm)	0.8	1.5	2
Iron (mg)	12	15	15
Vit. A. (IU)	5000	6000	8000
Ascorbic acid (mgm).	70	100	150
Thiamin (mgm)	1.1	1.8	2
Riboflavin (mgm)	1.5	2.5	3
Nicotinic acid (mgm)	11	18	20
Vitamin D (IU)	..	400-800	400-800

— American Pharmaceutical Journal

News Notes

BRITISH COLUMBIA

A recent district meeting of the R.N.A.B.C. was held at Mission when members from Abbotsford, Maple Ridge, New Westminster, and fourteen from Chilliwack were present. Each chapter gave a résumé of their activities since last May and, as each district was in the flood zone, considerable nursing and Red Cross work was reported. The next meeting will be at Abbotsford on February 23.

ABBOTSFORD:

Nineteen members were present at a recent

meeting of Matsqui-Sumas-Abbotsford Chapter when the highlight of the evening was Dr. McRae's interesting lecture on "Genetics." A report was given on the Fraser Valley District Association meeting attended by nine Abbotsford members. One hundred and sixty dollars was realized from the fall tea.

CHILLIWACK:

Miss Orton, second vice-president, was in the chair at a recent meeting of Chilliwack Chapter. A. Wiens, Ways and Means convener, reported on the successful rummage sale held in September. Mrs. D. Hayens told the members that two parcels had been sent overseas. The next parcel is to go to the mother of the chapter's "adopted" child. Five dollars a month "pin money" is going to a patient while in hospital undergoing an operation. This patient also lost all her personal possessions in the flood and, in addition to help from the Red Cross, it was felt that the chapter could do its bit also.

At the close of business colored films were shown by Dr. Epp. New members from the Coqualeetza and Chilliwack General Hospital were welcomed.

VANCOUVER:

St. Paul's Hospital:

A candy sale, bingo night, and rummage sale have been recent activities at the hospital. From Toronto comes word that a new auxiliary group of the alumnae is forming there, headed by Mrs. J. (Ecclestone) Maxwell. About a dozen known members are in that area and names and addresses of others would be welcomed.

Mary Egan succeeds Alix Kerr, long-time head of the surgery staff who has resigned. M. Anderson is in charge of the solution room, while L. Dietrich has replaced Mrs. H. Dobereiner as head nurse in the nursery. Mrs. Mitchell is in charge of the new eye, ear, nose and throat ward. H. Batstone has returned to the staff after post-graduate study in the east. Off to U.B.C. for a public health course is Miss Olivier, while M. Shand is leaving for McGill for a course in teaching and supervision in psychiatric nursing. E. Kunderman, bursary award winner, is in New York for study in medical nursing. Gwen Jones has returned from a year of exchange work in Ontario and is again with the North Vancouver Health Unit.

MANITOBA

Winnipeg General Hospital:

This year the class of 1928 celebrated their 20th anniversary, by way of a party at which several out-of-town classmates were present including: Mary (Gledden) Grasgaard, Hallack, Minn.; Janet Smith, Brandon; Vi (Nulin) Merritt, Valley City, N.D.; Florence (Taylor) Hinchcliffe, Swan River; Grace (Prout) McGugan, Fort Frances, Ont.; Margaret (Backman) Kusham, Selkirk; Anna Swail, Birds Hill, Man. All in all it was a very successful reunion and it is hoped that a bigger and better one may be held in 1953, including the

attendance of several graduates now living in Vancouver.

The class also celebrated by attending the alumnae dinner in honor of the 1948 graduates. The 1928-ers are proud to include among their members Mary Shepherd, the present alumnae president.

An interesting letter has been received from Robena MacLeod, a 1946 graduate now living in Los Angeles. She reports that there are a number of W.G.H. alumnae there and that they already have had two successful social gatherings.

NEW BRUNSWICK

SAINT JOHN:

Miss Seaman, the president, presided at a regular meeting of Saint John Chapter when there were forty-four members and four students in attendance. Miss Porter, St. Joseph's student, gave an interesting report of her visit to the N.B.A.R.N. annual meeting at Fredericton while Miss Van Wart, General Hospital student, reported on the student nurse workshop which she attended at the C.N.A. biennial convention at Sackville. As official chapter delegate, Mary Downing reported on the biennial convention giving the highlights, as did Mrs. Jas. Stirling concerning the provincial annual meeting.

As a money-making project for the N.B. A.R.N. it was decided that tickets be sold on a matched set of luggage, each registered nurse being asked to sell one book of tickets.

A social hour followed the meeting, when K. Bell, program convener, was in charge.

General Hospital:

Mary Scott, first vice-president, was in the chair at a recent meeting of the alumnae association when Avery Shaw was guest speaker. Mr. Shaw gave interesting sidelights on the various aspects of a curator's work and spoke of the many valuable objects now housed in the New Brunswick Museum.

Miss Hanscome read Miss Selfridge's report on the C.N.A. biennal convention. A letter from Mary MacDougall was read, telling of some of her nursing experiences among the natives of Angola, Africa. Letters were also read from grateful nurses in England who have received food parcels.

Maude Munro placed the wreath on the cenotaph on Armistice Day in memory of the Canadian nurses who gave their lives during two world wars.

Fran Higgins was the convener of the students' Hallowe'en dance held at the nurses' residence. The guests were received by Misses Murdoch and Peters. Pat Higgs and Barbara Baker were in charge of the decorations.

Prior to leaving for Hartland, to enter the N.B. Bible Institute as a student, Nora Murchison was honored by her associates on the fifth floor at a party, when Catherine MacLeod made the presentation of a McPherson plaid rug. Sonia Black poured tea, assisted by Miss MacLeod and Mrs. Sherwood. Among those present were L. Floyd, E. Heron, Dorothy Smith, and E. Rogers.

Helen Hoyt has resigned as assistant night supervisor to study at the N.B. Bible Institute. Janet Mealey is doing general duty at Goderich, Ont.

Provincial Hospital:

Margaret Horsman has resigned after four years' service, during which time she held many executive positions. Latterly, she was in the nursing office. She was presented with a well-filled purse on her departure. Her successor is Stella Murphy.

Marion Smith has returned from Scotland to resume her duties. The following are also on the staff: Mrs. Marie Carr, Verna Marr, Jorce Watling, Edna Grantham, Isabel Martin, Marion Ackerly, Daryl Fox.

NOVA SCOTIA

HALIFAX:

Children's Hospital:

At the recent graduation exercises of the school of nursing. Dr. A. E. Kerr, president of Dalhousie University, announced that the university would offer a post-graduate course to nurses as soon as the required staff could be recruited and circumstances afford the full-work course. Dr. Kerr said that the Red Cross would provide half the cost of the course for an experimental period of three years, and the board of governors hoped that by the time the course was ready the other half of the cost would be obtained.

Ruth Bailey and Gwennyth Barton, the first two Negro nurses to graduate in Canada, were among those who received their diplomas. Miss Bailey received a special prize for general proficiency, awarded by the Ladies Auxiliary of the hospital. Other prize winners included: Jennie Lawrence, general proficiency prize, awarded by the medical staff to the graduate who showed best all-round qualities as a nurse throughout her training; Janet Best, Lillian MacIntosh Memorial Award for Christian and womanly character; Belle MacKenzie, J. L. Hetherington prize for bedside nursing; Jean Rowley, prize for highest academic standing throughout the three-year training period; Janet Wilson, training school office prize for greatest co-operation and helpfulness.

ONTARIO

DISTRICT 4

ST. CATHARINES:

The Leonard Nurses' Home was the scene of a recent meeting of Niagara Chapter when the chairman, Catharine O'Farrell, presided and welcomed the large number in attendance. Special mention was made of the Sisters from Hotel Dieu, Kingston, who have opened a hospital in St. Catharines. Also in attendance were executive members of the district.

Reports were heard from the sections and committees as follows: Hospital and school of nursing, H. Brown; membership, E. Schuman; food parcels, S. Murray; public health, C. Goodes; general nursing, Mrs. M. Goldtorpe; special committee regarding the Ontario Nurses' Act, H. Brown.

Miss Goddard introduced the guest speaker, Edna L. Moore, director, Division of Public Health Nursing, Ontario Department of Health, and first-vice president of the R.N.A.O., who spoke on "Nursing Affairs." She stressed the responsibility of the association and the privilege of participating in all endeavors. Special reference was made to the Ontario Nurses' Act. D. Sharpe thanked the speaker and a presentation of roses was made to Miss Moore by the vice-chairman, B. Lousely. Flowers were also presented by Mrs. M. Sharpe to Anne Wright, superintendent of the General Hospital, for her hospitality.

A. Oram, district chairman, told the members of her experiences as counsellor and supervisor at a girls' camp at Oakville.

A social hour followed under the convenership of Miss Hanmer of the St. Catharines Department of Health. M. McCort, superintendent of nurses, Niagara Peninsula Sanatorium, and M. Goddard, public health director, St. Catharines, poured tea.

District 5

Barrie was the scene of a recent meeting of District 5 when nurses attended from Toronto, Orillia, Collingwood, Midland, Alliston, Oshawa, and Whitby. The afternoon session was given over to regular business of the district and to C.N.A. reports which were given by the chairman, Jessie Wallace, and Merle Ainlay, a student nurse from the Toronto General Hospital. Nettie Fidler, director of the Metropolitan School of Nursing at Windsor, and R.N.A.O. president, addressed the supper meeting, when 146 nurses were present. Miss Fidler described the organization and purpose of the demonstration school.

The district was happy to have as its guest, Miss Carter, who recently flew from England to accept a position on the teaching staff of the University of Toronto School of Nursing. Many of the international students at the school of nursing also took advantage of this opportunity to see Ontario in its fall splendor and also to observe the nursing organization in action.

District 8

Cornwall General Hospital:

Mrs. Harold Gunther's home was the scene of a recent meeting of the alumnae association when plans were made for a food and miscellaneous sale, the proceeds to go towards a room in the new wing of the hospital.

QUEBEC

Quebec City:

Jeffery Hale's Hospital:

At the opening fall meeting of the alumnae association, reports were read from the A.N.P.Q. annual meeting by Mrs. J. Green and A. MacDonald.

A new private and semi-private ward has been opened with Mrs. Davidson in charge. D. Moores has resigned to join the general duty staff at Verdun Protestant Hospital. G. Ward is on the staff of Grand'Mère Hospital. K. Traer has resigned to be married and

C. MacLeod and N. Power have gone to the Toronto General Hospital to do general duty. D. Rourke is with the hospital at Sydney, N.S., while Mrs. J. Barker is on the staff at Perley Home, Ottawa.

SHERBROOKE:

At a recent meeting of Sherbrooke Hospital Alumnae Association, Olive Harvey, past superintendent of the hospital, was presented with a gift from her alumnae. The newly-appointed superintendent, Vera Graham (see Nursing Profiles, Nov. issue) and Gertrude Callan, instructor of nurses, were welcomed and made honorary members.

Proceeds from a rummage sale were most satisfactory. Initial plans for the annual nurses' dance were made. A decision was made to continue sending parcels to British nurses and to Iola Beane, a missionary nurse in China. It was learned that Isabelle Miller has arrived in China to take up her studies at the university, prior to doing work as a missionary nurse. (See Nursing Profiles, Nov. issue.)

An interesting report of the C.N.A. convention in Sackville was given by the delegate, Noreen Malone.

Alfreda Dearden and Kay Vaughan are doing special duty at the hospital. D. Stevenson is now nurse in charge on the 3rd floor. Norma Beattie is on the staff of a Boston hospital and I. Williams is doing special duty there. Helen Porter is with the D.V.A. hospital in London, Ont.

SASKATCHEWAN

HUMBOLDT:

On July 11 St. Elizabeth's Hospital School of Nursing celebrated its 25th anniversary as a training school. It was also the date for the annual reunion of alumnae members. Newcomers to St. Elizabeth's staff are Mrs. J. (Sinnett) Loschuk and Jean Conby. Mrs. Joseph (Renner) Stockert is now residing in Humboldt.

MOOSE JAW:

The following have been appointed to Health Region 6: Mrs. G. Harkness and Mrs. P. Caven, nurse in charge of the public health clinic. Miss Robertson, V.O.N. supervisor, Ottawa, recently visited the regional health office.

General Hospital:

Grace Motta, superintendent of nurses, C. Lennie, and H. Hayes attended the C.N.A. convention in Sackville.

H. Downs, formerly superintendent of Lloydminster Hospital, is now annex supervisor. A. Holm, formerly dietitian at Toronto General Hospital, replaces V. McIntyre, who is now at the University Hospital, Edmonton. J. Ward and H. Wilson are supervisors of the surgical and medical wards, replacing Mrs. V. Brand and M. Redmond. The new science and nursing arts instructors are M. Forge and R. Noble. The following have joined the general duty staff: M. Colwill, M. Wildfang, G. Miller, and S. Whelan. For ten months Miss Whelan was industrial nurse

with the United Fruit Co. in the Panama Zone.

Providence Hospital:

Fourteen preliminary students were enrolled in the school in September.

The following appointments have been made to the nursing staff: Evelyn Matthewson replaces Helen Rutherford as medical clinical instructor. (For the past five years Miss Matthewson has been instructor at Edmonton General Hospital.) Marion Procter, surgical clinical instructor; Mrs. Fred (Fysh) Crosbie, obstetrical teaching supervisor; Margaret Holman, science instructor; Joyce Neal, dispensary.

Kay McGinn, scholarship student, is taking a post-graduate course in obstetrics at the University of Toronto. Marion Jameson is now a head nurse at Weyburn Mental Hospital. Jean McIntyre has been granted leave of absence to take the public health course at McGill School for Graduate Nurses.

PRINCE ALBERT:

At a recent meeting of the chapter, it was reported that thirty children had received regular doses of cod liver oil, donated by the chapter. It was also learned that twenty-five dollars had been raised from a rummage sale. Mrs. Nance of the Red Cross spoke on the proposed "Milk Service." If this plan materializes some of the chapter members will help.

Dorothy Mahaffy, of Holy Family Hospital, and Mrs. Isabella Welna, of Glasgow, Scotland, are now school nurses with the city. Mrs. Olive McKelvie is relieving on the sanatorium staff.

Holy Family Hospital:

Sr. Camillus is now hospital administrator and Sr. Regis is superior. Sr. Marie Germaine has returned from Saint John as assistant superintendent of nurses, replacing Sr. Loretta who is at St. Francis Xavier University, Antigonish, N.S. Katherine Nagle and Phyllis Simonson are science and clinical instructors. Noreen Lambert has left to join the staff of Edmonton General Hospital and Sr. Helen Marie is now superintendent of nurses, St. Joseph's Hospital, Saint John, N.B.

Victoria Hospital:

The new main entrance and switchboard are in operation. Inez Hamilton is supervisor of the private wing. Betty Goplin is O.R. supervisor at Col. Belcher Hospital, Calgary. The "Goplin Twins of 1948" are also on the staff of that hospital. D. Smith and V. Hansen are on the staff at Nipawin.

REGINA:

General Hospital:

Recent additions to the staff include Mmes I. Hunter, D. M. Taylor, and E. Bousfield.

Grey Nuns' Hospital:

The hospital has started a psychiatric affiliation class, sending two pupils for eight weeks, starting this September.

A welcome is extended to Rev. Sr. Tougas who has returned to be in charge of the women's medical floor. M. Crawford is nursing arts instructor with Sr. Mischau her assistant who is also health instructor.

SASKATOON:

City Hospital:

Over one hundred members of the alumnae association attended the annual reunion banquet when the guest speaker was Mrs. A. L. Caldwell. In her opening remarks, the president, M. R. Chisholm, mentioned that branch associations of the alumnae have been established in Vancouver, Toronto, and Montreal, the latter branch planning a reunion for 1951. Members who have not been in touch with the alumnae for some time are asked to contact their school of nursing so that an up-to-date mailing list may be compiled.

M. Lenore Long has returned to the staff after a year at Preeceville Hospital. Audrey Johnson is now on the maternity ward. She spent some time at the Vancouver General Hospital.

St. Paul's Hospital:

The Sodality this year is sponsoring an Emily Post Club with the first lecture in October.

Congratulations are extended to L. Rechemacher, science instructor, who has received her B.N. from McGill University.

Positions Vacant

WANTED

• AN ASSISTANT REGISTRAR •

The salary and conditions of employment will be made as attractive as possible. Special consideration will be given to candidates who have had experience in office and association work and who are otherwise qualified.

Applications should be submitted to the:

Committee on Appointments, Saskatchewan Registered Nurses' Association, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon, Sask.

WANTED

by the

CIVIL SERVICE OF BRITISH COLUMBIA

(OPEN COMPETITION)

PUBLIC HEALTH NURSES, GR. I

(*For the Department of Health, Province of British Columbia*)

• *Salary:* $186.00 per month, rising over five years to $212.00 per month (including current Cost-of-Living Bonus).

• *Qualifications:* Candidates must be eligible for registration in British Columbia and have completed a University degree or certificate course in Public Health Nursing.

Successful candidates may be required to serve in any part of the Province. Cars are provided.

Further information may be obtained from the

DIRECTOR, PUBLIC HEALTH NURSING, DEPARTMENT OF HEALTH, Parliament Buildings, Victoria.

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Application Forms obtainable from Government Agencies, the Civil Service Commission, Weiler Building, Victoria, or 570 Seymour St., Vancouver, ***to be completed and returned to the Chairman, Civil Service Commission, Victoria.***

Supt. for 20-bed hospital. Some obstetrical experience necessary. Apply, stating age, experience, qualifications, to Dr. D. H. Dixon, 78 Dundas St., Oakville, Ont.

Asst. Supt. of Nurses, with some background of experience, **Operating-Room Supervisor,** preferably with post-graduate experience, for 100-bed hospital with School of Nursing. Apply, stating time available for duty & salary expected, Supt. of Nurses, Sherbrooke Hospital, Sherbrooke, Que.

Asst. Night Supervisor (experienced graduate) for Vancouver General Hospital, B.C. Salary: $210 living out, plus $5.00 Cost of Living bonus. Alternating 40 & 48-hr. wk. Working hrs.: 12 midnight-8:00 a.m. Apply Director of Nursing.

Ward Supervisors for 220-bed Tuberculosis Sanatorium. Salary: $165 gross, less $30 for full maintenance. 44-hr. wk. 3 wks. annual vacation. Sick leave. Pension plan. Hospitalization. Group insurance. Salary increase after 6 mos. & yearly thereafter. Apply Supt. of Nurses, Fort William Sanatorium, Fort William, Ont.

CANADIAN RED CROSS SOCIETY

invites applications for Administrative and Staff positions in Hospital and Public Health Nursing Services for various parts of Canada.

The majority of opportunities are in Outpost Services in British Columbia, Saskatchewan, Ontario, Quebec, New Brunswick, and Nova Scotia. Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.

Graduate Nurses for Operating-Room (post-graduate course or experience desirable but not essential). Good salary. Living out. Apply Director of Nursing Service, Victoria Hospital, London Ont.

Staff Nurses, eligible for registration in Michigan, U.S.A., needed for all services in modern 200-bed hospital. Salary: $210 per month for 44-hr. wk. 6-mo. increase. $10 extra for 3-11 & 11-7 duty. 7 legal holidays. 12 vacation & 10 days' sick leave per yr. Cafeteria meal service. Laundry furnished. Room available at $10 per month. Apply Director of Nurses, General Hospital, Pontiac 18, Mich.

Graduate Nurses (2) for new, modern 20-bed hospital at Climax, Sask. Salary: $150 per mo. & full maintenance. 8-hr. day, 6-day wk. 2 wks. holiday with pay at end of 1st yr. Lively community near U.S. border. English-speaking population. Good climate. Apply P. J. Rasmussen, Sec., Climax, Sask.

General Duty Nurses. Salary: $125 per month with full maintenance. Apply Supt. of Nurses, Lady Minto Hospital, Chapleau, Ont.

Registered Nurses for 125-bed General Hospital in Interior of British Columbia. Salary: $150 gross; $30 deducted for room, board, laundry. 3 wks. vacation with pay after 1 yr. service. Accumulative sick leave, 12 days a yr. 7 statutory holidays. Apply, stating training, experience, post-graduate courses, Supt., Trail-Tadanac Hospital, Trail, B.C.

Nursing Arts Instructor for 165-bed hospital connected with large clinic. Capitol city with many interests. Salary open. Apply Director of Nurses, Bismarck Hospital, 6th & Thayer, Bismarck, North Dakota.

General Duty Nurses for modern 26-bed hospital. Salary: $120 with full maintenance. Straight 8-hr., 6-day wk. Permanent night nurse. 3 wks. holiday with pay after 1 yr. service. Situated 50 miles north of Calgary. Excellent train & bus service. Apply Miss M.A. MacDonald, Matron, Municipal Hospital, Didsbury, Alta.

General Duty Nurses for 80-bed General Hospital. Salary: $115 per mo. (including pay for O.R. call & bonus) plus maintenance. Increase at end of 6 mos. to $120 & at end of 1 yr. to $125. 8-hr. day, 6-day wk. 2 wks. holiday with pay (3 wks. given at end of 2nd yr.) Allowance for sick leave, hospitalization, statutory holidays. Additional $5.00 per mo. for 3:30 shift. Apply, stating qualifications, date available, Supt., Norfolk General Hospital, Simcoe, Ont.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock, and Toronto Psychiatric Hospital. Initial salary: $1,840 per annum, plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 weeks' vacation, statutory holidays and special holidays with pay. 8-hr. day, 6-day wk. Apply to Supt. of Nurses at above hospitals.

Registered Nurses for General Staff at Tranquille Sanatorium, situated on Kamloops Lake near Kamloops, B.C. Gross salary for 8-hr. day, 5½-day wk.: $174 per month during 1st yr., $186 per month for 2nd yr. & $5.00 raise per month in 3rd, 4th, and 5th yrs. of service, minus $27.50 for board, room, laundry. 31 days' vacation per annum with pay plus 11 days statutory holidays. 14 days sick leave each yr. accumulative with pay plus 6 days incidental illness. Superannuation Plan. Up to $50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

Registered Nurses for staff positions. Initial salary: $131.50 per month with full maintenance. Good living & working conditions. Apply Supt. of Nurses, Central Alberta Sanatorium, Calgary, Alta.

Applications are invited for the position of

• ASSISTANT SECRETARY •

for the Canadian Nurses' Association

Professional qualifications and experience should be described fully. Work to commence as soon after January 3, 1949, as possible.

Apply to:

Miss Gertrude M. Hall, General Secretary-Treasurer, Canadian Nurses' Association, Ste. 401, 1411 Crescent St., Montreal 25, Que.

District Nurse in Province of Alberta. Rural service. Emergency treatment, preventive and maternity program. Furnished cottage, fuel and water supplied. Salary schedule — $1920 - $2400, plus Cost of Living Bonus. Sick leave, annual vacation, superannuation. Apply to Director, Nursing Division, Department of Public Health, Edmonton, Alta.

Registered Nurses for Pediatric-Orthopedic Hospital. 8-hour day and 6-day week. Full maintenance or live out as desired. For further particulars apply to Supt., Shriners' Hospital for Crippled Children, Montreal Unit, Que.

Vancouver General Hospital has positions vacant for **General Staff Nurses.** Salary: $155 (plus laundry) increasing to maximum, $185. Extra $5.00 all-night rotation shifts. 4 wks' vacation & 11 statutory holidays with salary. Superannuation. Sick leave allowances. Registration in British Columbia essential. Apply Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

Operating-Room Nurses and General Staff Nurses. 44-hour wk. Starting salaries: $150. and $140 gross respectively. Registration in British Columbia essential. Apply Supt. of Nurses, Royal Columbian Hospital, New Westminster, B.C.

Registered Nurses for General Duty (3). Salary: $140 per month with full maintenance. New hospital with fully modern nurses' home in process of building. At present hospital of 30 beds on main line between Saskatoon & Calgary. Town of 1,500. Apply Miss E. Nixon, Matron, Union Hospital, Kindersley, Sask.

General Duty Nurses. Salary for Night Duty: $110 per mo.; Day Duty: $100 per mo.—both with room and board. Apply Supt., General Hospital, Kenora, Ont.

General Duty Nurses for modern 20-bed hospital. Salary: $135 per month with maintenance. 8-hr. day; 6-day wk. Usual holidays. Apply Miss A. Scott, Mayerthorpe Hospital, Alta.

Graduate Nurse for General Floor Duty. Salary: $110 monthly. Full maintenance & laundry. Blue Cross hospitalization plan. $60 yearly increase up to 3 yrs. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Supt. to take complete charge of 50-bed General Hospital with School for Nurses. Apply, giving full details of education, post-graduate training, experience & references, to Sec., Board of Trustees, Miramichi Hospital, Newcastle, N.B.

Nursery Supervisor with experience & post-graduate training. Also **Asst. Night Supervisor** preferably with some experience in Obstetrics & Operating-Room. 8-hr. duty. Apply Director of Nursing, Herbert Reddy Memorial Hospital, 4039 Tupper St., Montreal 6, Que.

Qualified Operating-Room Nurse for 188-bed hospital. Gross salary: $170 less $30 maintenance per mo. 44-hr. wk. **General Duty Nurses.** Salary: $115 plus full maintenance with $5.00 increase every 6 mos. up to $130. 44-hr. wk. Apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Industrial Nurse for Company Medical Dept. Preference given those with good experience in General Nursing & Public Health. Apply, giving qualifications, experience, age, salary expected & enclosing passport photo, to Medical Director, Imperial Oil Ltd., 56 Church St., Toronto 1, Ont.

Official Directory

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

Pres., Miss B. Emerson, 23 Rene LeMarchand Mns., Edmonton; Vice-Pres., Misses J. S. Clark, F. J. Ferguson; *Councillor*, Rev. Sr. Annunciata, Banff; *Committee Chairmen: Institutional*, Miss A. Anderson, Royal Alexandra Hosp., Edmonton; *Private Duty*, Miss O. J. Smith, Galt Hosp., Lethbridge; *Public Health*, Miss G. D. Hutchings, Strathmore; **Registrar, Miss E. B. Rogers, Reynolds Bldg., 10028-102nd St., Edmonton.**

Ponoka District, No. 2, A.A.R.N.

Pres., Miss Eleanor Stark; Vice-Pres., Miss Vera King; Sec.-Treas., Miss Valerie Wheeler, Prov. Mental Hospital, Ponoka; *Reps.* to: *Labor Relations*, Miss Florence Morrison; *Nurse Placement*, Miss Margaret McNinch; *The Canadian Nurse*, Miss Margaret Davies.

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Medicine Hat District, No. 4, A.A.R.N.

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Edmonton District, No. 7, A.A.R.N.

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Lethbridge District, No. 8, A.A.R.N.

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BRITISH COLUMBIA

Registered Nurses' Association of British Columbia

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New Westminster Chapter, R.N.A.B.C.

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East Kootenay District

Fernie Chapter, R.N.A.B.C.

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West Kootenay District

Trail Chapter, R.N.A.B.C.

Pres., Mrs. Phyllis Gavrilik; Vice-Pres., Miss Elin Johnson, Mrs. B. Farmer; Sec., Miss Alice Bush, Trail-Tadanac Hospital, Trail; Treas., Miss Helen Miller; *Publications Conv. & Rep. to Press & The Canadian Nurse*, Mrs. Alice Thornber.

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

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ONTARIO

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A.A., Ontario Hospital, Hamilton

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A.A., St. Joseph's Hospital, Hamilton

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A.A., St. Mary's Hospital, Kitchener

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A.A., Ontario Hospital, London

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A.A., St. Joseph's Hospital, London

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A.A., Victoria Hospital, London

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A.A., Ottawa General Hospital

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A.A., St. Luke's Hospital, Ottawa

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A.A., St. Joseph's General Hospital, Port Arthur

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A.A., St. Joseph's Hospital, Toronto

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A.A., Wellesley Hospital, Toronto

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A.A., Women's College Hospital, Toronto

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A.A., Children's Memorial Hospital, Montreal

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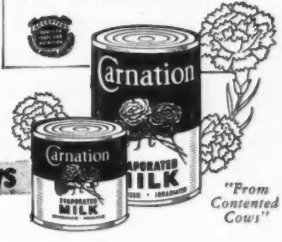

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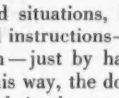

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